Indiana's Children's Health Insurance Program Annual Evaluation Report

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EP&P
Consulting, Inc.

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EXECUTIVE SUMMARY

Indiana's Children's Health Insurance Program (CHIP) offers the State a funding mechanism for receiving enhanced federal subsidies to provide health insurance to children who are not eligible for Medicaid. Indiana implemented its CHIP program in two phases:

- Phase I, which began July 1, 1998, expanded Medicaid to children below the age of 19 with family incomes of no more than 150% of the Federal Poverty Level (FPL). This phase is a Medicaid expansion and does not require members to pay monthly premiums.

- Phase II, which began January 1, 2000, is a non-Medicaid premium-share program designed to provide coverage to children with family incomes above 150% up to 200% of the FPL.

At the end of 2003 there were 64,142 children enrolled in CHIP—47,375 CHIP Phase I children and 16,767 CHIP Phase II children. The combined enrollment of the two phases grew 8% from 2002, as compared to 12% from 2001 to 2002. However, most of the growth in CHIP is in the Phase II portion, which grew 32% last year for the second year in a row.

This is the fourth evaluation of Indiana's CHIP conducted by EP&P Consulting, Inc. This year's report highlights trends in enrollment and services used by children in CHIP during calendar year (CY) 2003. Data from 2001 and 2002 is often shown for trend analyses. As was the case in previous years, this annual evaluation report includes both original analyses of eligibility and claims data as well as analyses of existing Hoosier Healthwise monitoring reports. Service utilization trends of children in Indiana's Medicaid program as well as available national CHIP and Medicaid data have been used as comparison benchmarks.

The questions at the outset of this year's CHIP evaluation process included:

- How does service utilization of children in CHIP compare with that of children in the Medicaid program (both in terms of the amount of services being utilized and the types of services)?

- Does service utilization vary between children enrolled under Phase I of CHIP (the Medicaid expansion) versus Phase II of CHIP (the premium share program)?

- How do the expenditures for services compare between children in CHIP Phase I, CHIP Phase II and Medicaid?

The findings of the annual evaluation report for the CHIP program for CY 2003 are very similar to the findings of the previous year. Overall enrollment grew at a slightly lower pace and this

would be expected in a program that is maturing. There were no systemic issues that affected enrollment into the CHIP or CHIP children's access to services. Available data also showed that the families of CHIP children gave the program higher marks for overall satisfaction than Medicaid members and higher than national studies for similar populations.

The populations of children under age 19 in CHIP and Medicaid have historically been quite different, and this has been the reason for differences in utilization rates. For example, there have traditionally been more teenagers in CHIP and more infants in Medicaid. Now, the distribution of children by age is more similar with the exception that the majority of infants are still enrolled in Medicaid. When this subgroup is removed from the analysis, the utilization rates of hospital, physician and pharmacy services between children in CHIP and Medicaid are very similar. The one service area that CHIP children have continually utilized more than Medicaid children in the past four years is dental services.

The percentage of CHIP children enrolled in managed care, specifically the Risk-Based Managed Care (RBMC) delivery system, continues to grow. By the end of 2003, more than one-third of all children in CHIP were enrolled in RBMC. In this system, services to children (except dental and some behavioral health services) are delivered through managed care organizations (MCOs). Growth in this portion of the program is directly related to the legislative mandate that some counties in the state are required to enroll Hoosier Healthwise members only in the RBMC delivery system.

Due to the differences in the size of the child populations in CHIP and Medicaid, payments for services were measured on a per member per month (PMPM) basis. The PMPM expenditures were measured for CHIP members (Phase I and II combined) against those for Medicaid children. Originally it was found that there were sharp differences between CHIP and Medicaid. However, after excluding children under age one from both groups, the differences diminished. For capitation payments made in the RBMC delivery system, the PMPM amount was almost identical ($72 for CHIP and $71 for Medicaid). In the combined PCCM and FFS delivery systems, the PMPM for CHIP children was only 91% of the PMPM for Medicaid children ($65 and $71, respectively). Last year we found similar results in the study of PMPMs in the PCCM and FFS populations.

On a service-specific basis, the only area where a CHIP member's per month payments was higher than Medicaid children was for dental services. The utilization trends between CHIP Phase I and Phase II are similar overall, and the expenditures incurred on a PMPM basis are slightly lower for Phase II members than Phase I members.

As Indiana's CHIP continues to mature, EP&P recommends that the state continue to monitor the program at a level consistent with what has been done in the past. However, the findings of this evaluation support some areas that should receive specific focus:

- ***Coordinate with the Office of Medicaid Policy and Planning (OMPP) on ensuring the completeness of shadow claims submissions.*** One of the persistent limitations in conducting this evaluation is the availability of utilization data submitted by the MCOs. Improving the timeliness of data by the MCOs, as well as its accuracy and completeness, has been on ongoing effort of the Quality Improvement Committee (QIC) in the Office of Medicaid Policy and Planning. In fact, this past year the QIC has made this a standing issue to be reported on by the MCOs at its monthly meeting to hold them more accountable. The QIC has reported that shadow claims submissions have started to improve in 2003. Despite this, the data shows that utilization of services for children in RBMC is lower than that of children in the Primary Care Case Management (PCCM) portion of the managed care system. The high potential of insufficient reporting of shadow claims by the MCOs is prohibiting us from establishing concrete findings related to utilization between CHIP members enrolled in the RBMC delivery system and those enrolled in the PCCM delivery system. We cannot state for certain, therefore, that lower utilization reported in RBMC means that children in the RBMC delivery system receive fewer services than their peers in PCCM. The CHIP Office is encouraged to work with the OMPP to determine if the timeliness of submissions is a larger issue with certain MCOs or with certain service types (e.g. hospital UB-92 claims or physician CMS-1500 claims).

  EP&P found that, for children age one and older, the state is paying $7 more on a per member per month basis for RBMC children in CHIP than PCCM/FFS children. For Medicaid children, however, the state is paying the same per month for RBMC children as it is for those in PCCM/FFS. Until shadow claims submissions are determined to be complete for 2003, we cannot assess whether or not this payment difference for CHIP children is justified.

- ***Continue to monitor and evaluate panel capacity.*** As of January 2004, 11 counties are at full capacity (100% or higher) of all of the slots available from pediatric providers to accept new members. This is four more counties than found last year. In addition, one-quarter (23) of all of the counties in the state have pediatric provider panel capacity filled above 80%. Although not entirely conclusive, this analysis may indicate that there are areas in the state where enrollment increases are outpacing available physician capacity. These counties should be further reviewed to determine which physicians are still available to accept new members. Additionally, it is suggested that the CHIP Office and the OMPP compare the panel capacity figures for each county against commercial plans. Although panel capacity may be an issue, it may be the case that the Hoosier Healthwise panel capacity is similar to that of commercial plans and that panel capacity issues are linked to broader state provider supply issues.

SECTION I
OVERVIEW OF FINDINGS

INTRODUCTION

The State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act. Title XXI offers states a funding mechanism for receiving enhanced federal subsidies to provide health insurance to children who are not eligible for Medicaid. In implementing SCHIP, states had the option of providing benefits through an expanded Medicaid program, by establishing a separate non-Medicaid program, or through a combination of these two program designs.

Indiana's CHIP was designed as a "combination" program and was implemented in two phases:

- Phase I, which began July 1, 1998, expanded Medicaid to children below the age of 19 with family incomes of no more than 150% of the Federal Poverty Level (FPL).

- Phase II, which began January 1, 2000, is a non-Medicaid premium-share program that provides coverage to children with family incomes above 150% of the FPL up to 200% of the FPL.

Indiana's Office of the Children's Health Insurance Program in conjunction with the Office of Medicaid Policy and Planning (OMPP) manage the CHIP program. Eligibility determination is conducted by the Division of Family and Children (DFC). Together, these divisions are responsible for the operation of the Hoosier Healthwise benefits programs, including CHIP. The model for delivering services to CHIP members is the same as it is for children in the rest of Hoosier Healthwise.

FINDINGS

This is the fourth annual evaluation of Indiana's CHIP conducted by EP&P Consulting, Inc. (EP&P). As in past years, our evaluation focuses on the most recent data available to identify trends in enrollment, service utilization, payments, access to services/providers, and quality monitoring. The evaluation includes analyses of service claims for the period January 2001 to December 2003 to:

- Determine if children enrolled in Phase II access and utilize services in the same manner as children enrolled in Phase I and if there have been any changes since prior evaluations.

- Determine if children enrolled in CHIP are utilizing services in a manner similar to Medicaid children and if there have been changes since prior evaluations.

- Determine if there are differences in utilization patterns among the three types of service delivery models within Hoosier Healthwise—the Primary Care Case Management (or PCCM) system, the Risk Based Managed Care (or RBMC) system, and the Fee-For-Service (or FFS) system.

- Determine if differences in per member per month (PMPM) expenditures between CHIP Phase I, CHIP Phase II and children in Medicaid is a result of differing utilization patterns, cost of services, or subpopulations by age group.

- Determine if there are differences in PMPM payments between the RBMC delivery system (paid as a monthly overall amount for all major services) and the PCCM/FFS delivery systems (paid on a claim-by-claim basis as the services are incurred). If one delivery system resulted in higher PMPM payments than the other, determine if there is an underlying reason for the difference.

- Determine if there are differences in utilization and expenditure patterns between age groups to better understand the underlying differences between CHIP and Medicaid. Past evaluations found that the composition of the ages within a program (e.g. more teenagers in CHIP Phase I, more infants in Medicaid) often drove differences in both utilization and payment.

- Determine if there are any systematic access or quality issues that have changed between calendar year 2002 and 2003 that would change findings from the annual evaluation report submitted on April 1, 2003.

Available national and state-level data was obtained as comparative benchmarks with which to measure Indiana's CHIP program. The evaluation also included analyses of internal reporting documents provided by the OMPP that focused on monitoring.

This section of the evaluation provides a summary of findings related to the above issues while the remaining sections of the report provide more detailed analyses results.

What is the enrollment trend for the CHIP program? How does it compare to prior years?

At the end of 2003 there were 64,142 children enrolled in CHIP—47,375 CHIP Phase I children and 16,767 CHIP Phase II children. The combined enrollment of the two phases grew 8% from 2002 to 2003, as compared to 12% from 2001 to 2002. After years of rapid growth, the increase in enrollees in the overall CHIP is starting to subside. However, enrollment growth between the two phases of Indiana's CHIP remain quite different. Enrollment growth in CHIP Phase II this year once again exceeded 30%, whereas growth in CHIP Phase I has flattened (up 2% from 2002 to 2003).

What is the rate of disenrollment for the CHIP program?

Studies conducted in the last two years showed that over 40% of children who enrolled as members in CHIP were no longer enrolled one year after their start date. This excluded those children who were no longer eligible because they turned age 19. The high rate of disenrollment is reflected in the average period of enrollment for CHIP members, which is between 9 and 10 months.

Why is the rate of disenrollment in the CHIP program so high?

It is unclear without further analysis why members remain in the program for such a short period of time. One reason may be that families are using the CHIP program as a temporary measure to replace lost health insurance coverage from the private sector or other sources. This is possible since Indiana ranks 9th nationally among states for the percentage of children covered by health insurance from a parent or guardian's employer. There is little information on CHIP disenrollment nationwide, but studies in recent years in Colorado showed similar disenrollment rates and New York had disenrollment rates between 25 and 50 percent. It should be noted, however, that CHIP members have continually given higher ratings of satisfaction than other members of Hoosier Healthwise, so it does not appear that high disenrollment relates to dissatisfaction with the program.

How do children enrolled in CHIP Phase I use services relative to those in CHIP Phase II?

Service utilization was measured in two ways: the percentage of children accessing services and the number of claims per 1,000 eligible and enrolled children. For the major categories of service studied (hospital, physician, dental, and pharmacy services), the percent of unique children in CHIP Phase I (non-premium share) that used each of these services was similar to the percent of unique children in CHIP Phase II (premium share) that used these services. This has held true since 2001. The percent of enrollees that used *any* service in both CHIP programs has been between 70% and 80% since 2001. When compared to other states, Indiana's children in Hoosier Healthwise are accessing these services at the same or higher rate than children in neighboring states. The reason why the percent of utilizers is not higher than 80% is most likely due to the transitory nature of the population that has a low average period of enrollment.

Service utilization was also measured on a "claims per 1,000 eligibles" basis since the size of the two CHIP phases are quite different. Measuring against this factor, CHIP Phase I and II share similar utilization patterns for outpatient hospital and pharmacy services. CHIP Phase II has higher utilization, however, for primary care physician visits and dental services whereas CHIP Phase I has higher utilization for inpatient hospital services.

How does CHIP (Phases I and II) utilization compare to Medicaid children under the same services?

Service utilization patterns differed between Medicaid and CHIP depending upon the service reviewed. However, some of this can be attributed to the large population of infants in the Medicaid program which is not a part of CHIP (because most infants in low-income families are eligible for Medicaid already). CHIP children had higher utilization for dental services, whereas Medicaid children had higher utilization for hospital and physician services. Pharmacy utilization was similar between the two programs. It should be noted that these findings were also reported last year and that the relative differences between the two programs for each service have remained similar since 2001.

How do the per member per month (PMPM) expenditures compare between CHIP and Medicaid?

The PMPM expenditures from state fiscal year 2003 were measured for CHIP members (Phase I and II combined) against those for Medicaid children. Expenditures were summarized for hospital, physician and pharmacy services. Dental services were not included because this is not covered by the MCOs in the RBMC delivery system. Originally it was found that there were sharp differences between CHIP and Medicaid. However, after excluding children under age one from both groups, the differences diminished. For capitation payments made in the RBMC delivery system, the PMPM amount was almost identical ($72 for CHIP and $71 for Medicaid). In the combined PCCM and FFS delivery systems, the PMPM for CHIP children was only 91% of the PMPM for Medicaid children ($65 and $71, respectively). Last year we found similar results in the study of PMPMs in the PCCM and FFS populations.

Between the two portions of CHIP, payments per month in the RBMC delivery system were higher for CHIP Phase II ($79) than CHIP Phase I ($71). In the PCCM and FFS delivery systems, the opposite was true. The PMPM for children in CHIP Phase II ($54) was lower than that for children in CHIP Phase I ($69). It should be noted, however, that the PMPMs were lower in the PCCM/FFS delivery systems for both CHIP Phase I and Phase II.

For State Fiscal Year 2003	CHIP Phase I	CHIP Phase II
RBMC Payments PMPM	$70.52	$79.22
PCCM/FFS Payments PMPM	$69.30	$54.03

*The few children under age 1 in CHIP Phase II were excluded from this analysis

Are there differences in CHIP service utilization by type of delivery system (PCCM versus RBMC versus Fee-For-Service)?

For CHIP Phase I, 84% of children on average were enrolled in a managed care portion of Hoosier Healthwise (RBMC or PCCM) in 2003; for CHIP Phase II, it was 74%. The number of enrollees in RBMC increased eight percentage points for both CHIP Phase I and Phase II from 2002 to 2003. This is due to a legislative mandate requiring that certain counties enroll Hoosier Healthwise members only in the RBMC delivery system.

This movement of members to RBMC is not carrying through on utilization trends. This year's results for utilization (measured on a claims per 1,000 eligibles basis) proved to be similar to last year's in that utilization in the PCCM delivery system surpasses (in some instances significantly) that in the RBMC delivery system. The only exception to this is dental services, where this year and last year we found utilization to be the same for children in both delivery systems. This presents a dilemma in establishing findings for the other service types. This is because dental services are not performed by the MCOs like other major services and therefore are not reported by MCOs. Therefore, it is unclear whether or not the lower utilization for RBMC in other services is "real" or is an artifact of insufficient reporting by the MCOs.

The remaining children are enrolled in the FFS portion of the program. Most of these children are in FFS for a short period while selecting a doctor in the PCCM or RBMC delivery systems. Therefore, utilization in the FFS portion of the program is more volatile due the short-term needs of members in their earliest month(s) of enrollment.

Are there service utilization differences by age?

Since the initial group of teenagers eligible for CHIP Phase I aged out of the program completely in 2002, the composition of members in CHIP Phase I more closely resembles those in CHIP Phase II and Medicaid. Therefore, the variation in service utilization across the programs has been mitigated to the point that real differences only occur between children in CHIP and children in Medicaid for inpatient hospital and physician services. However, this is because of the large population of infants in Medicaid. When the infants are removed from the analysis, utilization is similar by age group between CHIP Phase I, CHIP Phase II, and Medicaid children.

When differences in members' ages were controlled within the evaluation, there were also similarities in average payments per claim between CHIP Phase I, CHIP Phase II, and Medicaid. The age categories studied were age 1-5, 6-12 and 13-18. For all three programs, children aged 13-18 had higher average payments for physician and dental claims. For pharmacy services, average payments for children aged 6-12 and 13-18 were similar and both higher than for children aged 1-5. For inpatient hospital services, higher average payments occurred for children aged 1-5. No difference in the average payments per claim across age groups was found for outpatient hospital services.

AREAS FOR FURTHER RESEARCH

This evaluation of Indiana's CHIP program has identified areas that the CHIP Office may wish to explore to gain a better understanding of trends occurring in the program:

- ***Coordinate with the Office of Medicaid Policy and Planning (OMPP) on ensuring the completeness of shadow claims submissions.*** The OMPP, through its Quality Improvement Committee, has reported that shadow claims submissions have started to improve in 2003 as the QIC has held the MCOs accountable to report their status on this issue each month. However, for all services researched where MCOs are required to submit shadow claims, the utilization per 1,000 CHIP members was lower in the RBMC delivery system than in the PCCM delivery system. It is unclear at this time how accurate it would be to state that this means that children in the RBMC delivery system receive fewer services than their peers in PCCM. The CHIP Office is encouraged to work with the OMPP to determine if the timeliness of submissions is a larger issue with certain MCOs or with certain service types (e.g. hospital UB-92 claims or physician CMS-1500 claims).

  EP&P found that, for children age one and older, the state is paying $7 more on a per member per month basis for RBMC children in CHIP than PCCM/FFS children. For Medicaid children, however, the state is paying the same per month for RBMC children as it is for those in PCCM/FFS. Until shadow claims submissions are determined to be complete for 2003, we cannot assess whether or not this payment difference for CHIP children is justified.

- ***Continue to monitor and evaluate panel capacity.*** The map shown at the end of Section IV shows that as of January 2004, 11 counties are at full capacity (100% or higher) of all of the slots available from pediatric providers to accept new members. This is four more counties than found last year. In addition, one-quarter (23) of all of the counties in the state have pediatric panel capacity filled above 80%. Pediatric providers include general practitioners, family practitioners, and pediatricians. Although not entirely conclusive, this analysis may indicate that there are areas in the state where enrollment increases are outpacing available physician capacity. These counties should be further reviewed to determine which physicians are still available to accept new members. Additionally, it is suggested that the CHIP Office and the OMPP compare the panel capacity figures for each county against commercial plans. Although panel capacity may be an issue, it may be the case that the Hoosier Healthwise panel capacity is similar to that of commercial plans and that panel capacity issues are linked to broader state provider supply issues.

CONCLUSION

Indiana's CHIP has and continues to achieve success in a number of areas. Some of these include:

- ***Enrollment continues to increase.*** Enrollment in CHIP was at its highest point ever at the end of 2003. Enrollment continues to grow at a rate above 30% for CHIP Phase II in its fourth year of existence.

- ***Disenrollment remains high as well, but not due to dissatisfaction.*** Although the disenrollment rate has not changed in the last few years, member satisfaction measured on annual surveys remains at an all-time high. Therefore, it is implied that members are disenrolling for reasons other than dissatisfaction with the program.

- ***Service utilization per member is steady for most services.*** Utilization of inpatient hospital, outpatient hospital, primary medical physicians, specialist physicians, pharmacy scripts and dental services followed similar trends in 2003 as in 2002 when measured on a "claims per 1,000 eligibles" factor. Therefore, it can be inferred from an access standpoint that the level of service delivery is not being impacted by enrollment increases (except for potentially a few counties that may need additional primary medical providers).

  The one area that may be cause for concern is that physician utilization (especially primary care) for children in CHIP Phase I remains lower than CHIP Phase II and Medicaid in 2003. Originally thought to be due to the disproportionate share of teenagers in Phase I early on in the program, this group has now aged out of the program completely in 2003. Therefore, there may be another underlying reason for lower physician utilization in CHIP Phase I.

- ***Dental utilization continues to increase.*** Dental utilization increased for children in both CHIP and Medicaid in 2003. CHIP members have always utilized dental services at a higher rate than their counterparts in Medicaid, and this trend continued in 2003 as utilization levels reached their highest level since the inception of the CHIP program.

- ***There is not adverse selection between CHIP Phase I and CHIP Phase II.*** The utilization trends between CHIP Phase I and CHIP Phase II are similar to one another overall as well as similar to Medicaid, and the expenditures incurred on a per member per month basis are slightly lower for Phase II members than Phase I members.

- ***RBMC utilization remains inconclusive.*** The high potential of insufficient reporting of shadow claims by the MCOs prohibits findings related to utilization between CHIP members enrolled in the RBMC delivery system and those enrolled in the PCCM

delivery system to be finalized or conclusive. It is also unclear whether or not the state is achieving a fair value from the MCOs without obtaining this potential missing data.

- ***More CHIP members joined the risk-based managed care (RBMC) delivery system in 2003.*** Although there will always be some children in the FFS portion of the program for a short term before they select a PMP, the percentage of children in RBMC increased eight percentage points in 2003 for both CHIP Phase I and CHIP Phase II. This is partially due to the implementation of seven mandatory managed care counties by the end of 2003 and six more slated for 2004. For CHIP Phase I, the percentage enrolled in RBMC grew from 30% to 38% from 2002 to 2003; for CHIP Phase II, the percentage grew from 25% to 33%.

- ***Overall satisfaction with the program remains high.*** Families of children enrolled in CHIP who were surveyed in the most recent annual member survey administered by the OMPP gave more favorable ratings to many questions than Medicaid members of Hoosier Healthwise as well as respondents from national surveys. Among CHIP members, 94% rated the Hoosier Healthwise program "very good" or "good" as compared to the national average of 87% for similar surveys of children in Medicaid programs. Ratings for Hoosier Healthwise primary care doctors and specialists were rated "very good" (92% and 77%, respectively) at a much higher rate than national ratings (66% and 62%, respectively).

SECTION II
OVERVIEW OF INDIANA'S CHILDREN'S HEALTH INSURANCE PROGRAM

This evaluation of Indiana's Children's Health Insurance Program (CHIP) will address enrollment, service access, service utilization, cost trends and quality monitoring. Before findings in these areas are presented, this section provides general background information about the programmatic design underlying Indiana's CHIP. This information will assist in understanding the findings presented in later sections of this report.

What is the State Children's Health Insurance Program (SCHIP)?

The State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 as Title XXI of the Social Security Act. Under SCHIP, states could develop programs offering health coverage to children up to age 19 in families who are not eligible for Medicaid. In implementing SCHIP, states had the option of providing benefits by expanding their existing Medicaid program, by establishing a separate non-Medicaid program, or through a combination of these two program designs. Indiana has a "combination" program. Children are determined eligible based upon a family's income level. These income limitations vary across the states based on each state's SCHIP design. Indiana's income level for eligibility purposes is capped at 200% of the federal poverty level (FPL), or $36,800 in 2003 for a family of four. This is the level most widely used by state CHIP programs nationwide.

Similar to Medicaid, Title XXI is a joint federal-state funded program with states receiving federal-matching dollars. Title XXI offers states a federal allotment for their SCHIP programs. The amount the federal government pays to each state depends on the state's SCHIP federal matching rate. The SCHIP federal matching rate is a percentage of the total program costs that the federal government will pay. (The term "enhanced" is often used when referring to the SCHIP federal matching rate because the SCHIP matching rate was set at a higher percentage than the Medicaid matching rate as an incentive for states to participate in the Title XXI program.)

The SCHIP federal matching rate differs from state to state because it is based on the state's share of low-income and uninsured children. A state's share of low-income and uninsured children is determined through estimates from the Current Population Survey, conducted by the U.S. Census Bureau. A state cannot receive a matching rate of more than 85% and cannot receive an annual payment of less than $2 million. Indiana's SCHIP federal matching rate was 73.38% in Federal Fiscal Year 2003.

What is Indiana's Children's Health Insurance Program?

Indiana's CHIP was designed and implemented in two phases. Phase I was designed as a Medicaid expansion. Phase I began in October 1997 and extended Medicaid eligibility to children not previously eligible for Medicaid who:

- Were born before October 1, 1983 and
- With family incomes up to 100% of the Federal Poverty Level (FPL); 100% FPL in 2002 was $18,100 for a family of four

The last of these children enrolled in CHIP reached the age of 19 on September 30, 2002 and were, therefore, not in the program in 2003.

In July 1998, this Phase I Medicaid expansion continued by extending eligibility to a second group of children:

- Children from age one through age five with family income between 133% and 150% of FPL who were not previously eligible for Medicaid; and
- Children from age six through age 18 with family income between 100% and 150% of FPL who were not previously eligible for Medicaid

Throughout the remainder of this report this first phase of Indiana's implementation of its CHIP will be referred to as CHIP Phase I. Enrollment in CHIP Phase I in December 2003 was 47,375 children.

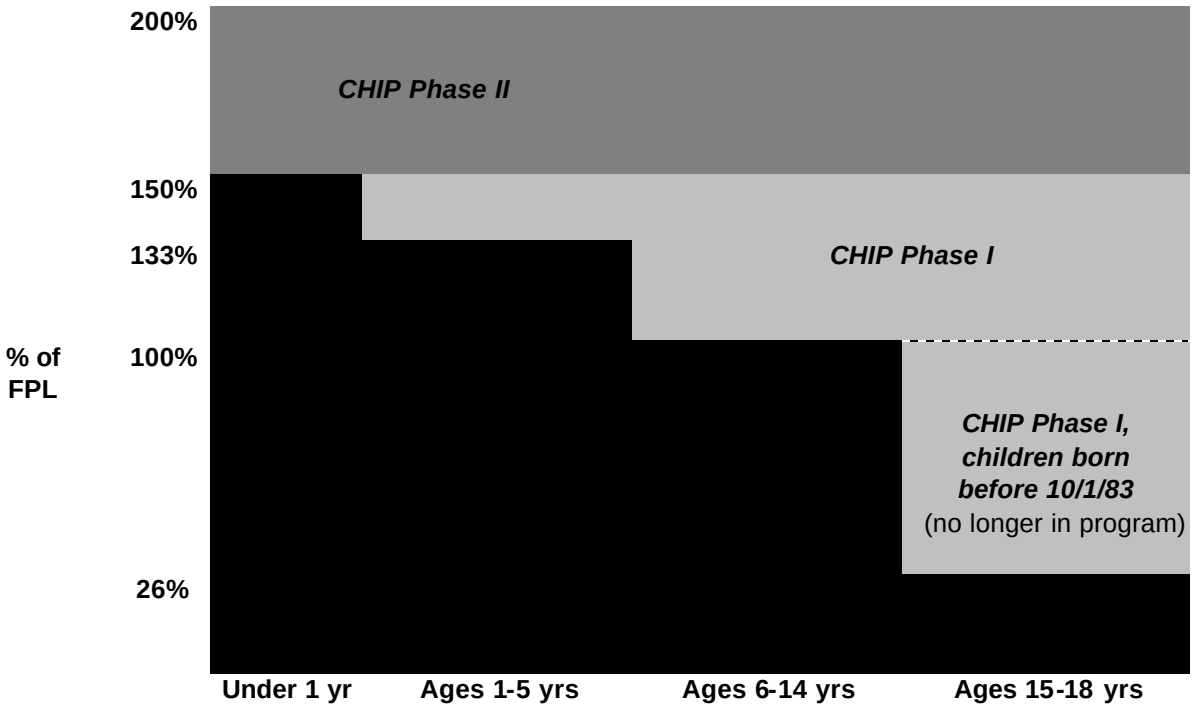
Phase II of Indiana's CHIP was designed as a state-specific, non-Medicaid expansion. Implemented in January 2000, this phase further expanded access to health care coverage by extending eligibility to:

- Children from birth through age 18 and
- With family income above 150% and up to 200% of FPL

Because the second phase is a state-defined program, the State had more flexibility in designing the program. The State used this flexibility to create a package that differs slightly from the Medicaid managed care benefit package and requires members to pay premiums and co-payments. Also, because this phase is not a Medicaid expansion, coverage is not an entitlement. In addition, the benefit package does not include all of the services required under Medicaid. *This second phase of Indiana's CHIP implementation will be referred to throughout the remainder of the report as CHIP Phase II.* As of December 2003, enrollment in the CHIP Phase II was 16,767 children.

Overall program enrollment in both phases of Indiana's CHIP totaled over 64,000 at the end of 2003.

The diagram below illustrates the "stair-step" eligibility process for children in CHIP.



Hoosier Healthwise uses the Federal Poverty Level (FPL) for income guidelines.
For a family of four in 2003, 150% of FPL was $27,600 and 200% of FPL was $36,800.

How do children in Indiana's CHIP receive health care services?

Children enrolled in both the Medicaid expansion (CHIP Phase I) and the Premium Share Program (CHIP Phase II) portions of Indiana's CHIP receive health care services through the existing Medicaid delivery system, Hoosier Healthwise.

The Hoosier Healthwise delivery system is a multi-faceted delivery system, including two managed care delivery systems existing side-by-side – a primary care case management (PCCM) system and a risk-based managed care (RBMC) system, and a fee-for-service (FFS) system.

- Under the PCCM delivery system, the State contracts with primary medical providers (PMPs), and the PMPs provide or authorize most preventive and primary care services. Certain services, including mental health, family planning, dental, pharmacy, and transportation do not require PMP authorization. Providers are paid a

per member per month case management fee and medical services are paid on a FFS basis.

- Under the RBMC delivery system, the State contracts with managed care organizations (MCOs) to provide comprehensive preventive and primary care services. MCOs are paid a capitation rate per member per month. The MCOs then contract directly with PMPs and other providers either under a capitation or a FFS arrangement. Certain services, including dental services and services delivered by mental health providers, are not covered under the capitation rate.

- When members first become eligible for Hoosier Healthwise managed care, there is an initial period of time referred to as the "Fee-For-Service" (FFS) window. During this time period, members are covered by Hoosier Healthwise but are not yet enrolled in a managed care program (PCCM or RBMC). The FFS window allows members time to review their coverage options and to select a PMP. It also provides time for the selected physician to receive notification about his/her selection as the member's PMP. This FFS window accounts for the majority of members and utilization identified as FFS within this evaluation. Within the FFS system, a member can receive services from any doctor participating in the Hoosier Healthwise program. The Hoosier Healthwise program enrolls children in either the PCCM or RBMC delivery systems so that they may be linked with a PMP.

The selection of a primary medical provider determines the delivery system from which a child receives services. For example, when children are determined eligible for Hoosier Healthwise, their family selects a primary medical provider (referred to as a PMP). The child is then enrolled in the delivery system in which the PMP participates. Therefore, the delivery system under which children receive services is relatively transparent to the members.

Who administers Indiana's CHIP?

The State's Family and Social Services Administration (FSSA) has a number of divisions involved in the operation of Indiana CHIP:

- The Office of the Children's Health Insurance Program (the CHIP Office). Public Law 273-1999, the legislation authorizing Phase II of CHIP, created the CHIP Office and charged them with the responsibility of designing and administering Phase II.

- The Office of Medicaid Policy and Planning (OMPP) is the designated single state agency for Medicaid. The Hoosier Healthwise program is operated by the Managed Care unit of the OMPP.

- The Division of Family and Children (DFC). CHIP eligibility determination is conducted by the DFC.

SECTION III
ENROLLMENT, UTILIZATION AND EXPENDITURE FINDINGS

INTRODUCTION

This section of the report provides detailed information on enrollment and utilization trends. In addition, this section presents the results of analyses of expenditures from the perspective of which services are being purchased in general as well as payments made on a per member per month (PMPM) basis. For each of the analyses, trends across the following populations were evaluated:

- Children in CHIP Phase I
- Children in CHIP Phase II
- Children in CHIP Phases I and II combined
- Children in Medicaid

It should be noted that children in Medicaid were included for comparison purposes. Throughout this report, the term "Medicaid" refers only to the children in Medicaid that are eligible to participate in managed care.

Service utilization and payment trends were analyzed for these populations across multiple dimensions including:

- Expenditures per member per month (for PCCM and FFS claims)
- Capitation payments made per member per month (for RBMC members)
- Utilization on a claims per 1,000 eligibles basis for RBMC, PCCM and FFS
- Expenditures by age group (PCCM and FFS claims only)

Services covered under the RBMC system are not included in the expenditure analyses because managed care entities are paid a capitation rate per member per month and their claims do not reflect payments on a per service basis. However, the managed care entities in the RBMC system are required to submit to the State details on all of the services they have provided, even though they do not contain payment information on them. These claims, commonly referred to as "shadow claims", are included in the utilization analyses mentioned above.

The paid claims from the PCCM and FFS systems and shadow claims from the RBMC system evaluated for this report represent services utilized during the period from January 1, 2001 through December 31, 2003. Because of the timing of this report, not all claims for the latter half of calendar year 2003 may be represented because providers are still submitting claims for payment. This is especially true for inpatient hospitalization claims. Therefore, throughout this section, when utilization trends are shown graphically, it should be noted that the latter portion of this trend might be underestimated due to the incompleteness of the data.

COMPARISONS TO THE 2003 REPORT

Key trends in enrollment, utilization and payment compared to last year's report can be summarized as follows:

- Enrollment. After years of rapid growth, the increase in enrollees in the overall CHIP is starting to subside. However, enrollment growth between the two phases of Indiana's CHIP remain quite different. As reported last year, enrollment growth in CHIP Phase II (children in families with incomes of 150%-200% of the federal poverty level) this year once again exceeded 30%. In CHIP Phase I (children in families with incomes up to 150% of the federal poverty level), however, where there was some small growth reported last year (up 7% from 2001 to 2002), the growth was even smaller this year (2% from 2002 to 2003).

- Member Retention. The average number of months that CHIP members were enrolled in the program remained the same from 2002 to 2003 at between 9 and 10 months. The short enrollment periods in CHIP might suggest that families are using the CHIP program as a temporary measure to replace lost health insurance coverage from the private sector or other sources. Studies conducted in the last two years showed that over 40% of children who enrolled as members in CHIP were no longer enrolled one year after their start date.

- Method of Service Delivery. The percentage of CHIP children who were enrolled in the managed care portion of the program (PCCM and RBMC) in 2003 was the same as that in 2002. However, more of these children were enrolled in the RBMC delivery system in 2003 than in 2002. For CHIP Phase I, 84% of children on average were enrolled in managed care in 2003; for CHIP Phase II, it was 74%. The number of enrollees in RBMC increased eight percentage points for both CHIP Phase I and Phase II from 2002 to 2003. The reason for the increase in enrollment in the RBMC delivery system is due to the legislative mandate that certain counties in the state accept Hoosier Healthwise members only in the RBMC delivery system.

- Percentage of Members Using Services. The percentage of CHIP enrollees who used particular services (specifically hospital, physician, dental and pharmacy) as compared to the total number of enrollees who were eligible to use the services remained steady around 70% between 2002 and 2003. We also reported that there was little change from 2001 to 2002. Also, the percent of CHIP members using these services was slightly lower than that of children in the Medicaid program (except for dental services). Further, when compared to other states, Indiana's children in Hoosier Healthwise access these services at the same or higher rate than children in neighboring states. The reason why the percent of utilizers is not higher than 70% is most likely due to the transitory nature of the population that has a low average period of enrollment.

- Overall Service Expenditures Per Member Per Month (PMPM). The PMPM expenditures were measured for CHIP members (Phase I and II combined) against those for Medicaid children. Originally it was found that there were sharp differences between CHIP and Medicaid. However, after excluding children under age one from both groups, the differences diminished. For capitation payments made in the RBMC delivery system, the PMPM amount was very similar ($72 for CHIP and $71 for Medicaid). In the combined PCCM and FFS delivery systems, the PMPM for CHIP children was only 92% of the PMPM for Medicaid children ($65 and $71, respectively). Last year we found similar results in the study of PMPMs in the PCCM and FFS populations.

- Overall Utilization Across Delivery Systems. This year's results proved to be similar to last year's in that utilization of most services in the PCCM delivery system surpasses (in some instances significantly) that in the RBMC delivery system. The only exception to this is dental services, where we found utilization to be slightly higher for children in the RBMC delivery system. Dental services are not performed by the MCOs like other major services and therefore are not reported by MCOs. The RBMC delivery system does provide for the remaining services studied (hospital, physician, and pharmacy). Therefore, because RBMC utilization was found to be lower than PCCM for these other services, it is unclear whether or not the lower utilization is "real" or is an artifact of insufficient reporting by the MCOs.

- Inpatient Hospitalization. Children in CHIP continue to have lower utilization of inpatient hospital care than their counterparts in Medicaid as has been the case for the last three years. As a result, monthly PMPM expenditures (PCCM and FFS delivery systems) for inpatient hospital services remain 51% lower for CHIP children than Medicaid children in 2003. When children under age one are removed, however, the difference is 27% lower for CHIP.

- Outpatient Hospital Services. Like inpatient hospital services, children in CHIP utilize outpatient hospital services less than children in Medicaid. The PMPM expenditures for CHIP members have remained steady from 2002 to 2003 and remained lower than the Medicaid PMPMs for this service in 2002 and 2003. There continues to be little difference in average payments per claim for outpatient services by age group.

- Physician Services. Last year's trend for utilization of primary medical provider (PMP) services continued this year. Children in CHIP Phase I once again used this service less than children in Medicaid, whereas children in CHIP Phase II utilized PMP services at about the same rate as Medicaid children. Utilization of non-PMP (specialist) services had smaller differences between CHIP Phase I and CHIP Phase II or Medicaid.

PMPM expenditures for PMP and non-PMP services were almost the same for CHIP and Medicaid members in 2003 as they were in 2002. This is after the children under age one were excluded from the analysis in both programs.

- Pharmacy Services. Children in CHIP Phase I, Phase II and Medicaid continue to use pharmacy services at the same rate. This was also our finding last year. The seasonal nature of higher utilization in the winter months found last year continued this year. This impacts the PMPM expenditures on a monthly basis. However, over the year, expenditures on a PMPM basis for CHIP Phase I and Medicaid remained similar throughout 2002 and 2003 while CHIP Phase II PMPM expenditures remained below the others by about $8 per month. The average payment per claim for CHIP Phase II children remained the same from 2002 to 2003. This also held true for Medicaid children. However, the average payment per claim for CHIP Phase I children increased 7% from 2002 to 2003.

- Dental Services. Since we began reporting this three years ago, children in CHIP continue to use dental services at a higher rate than children in the Medicaid program. Children in CHIP Phase II no longer use dental services more often than children in CHIP Phase I, as had been reported in prior years. The PMPM expenditures for CHIP and Medicaid children grew more than 10% from 2002 to 2003. Similar to last year's findings, the average payments per claim for dental services were highest among children ages 13-18 for CHIP and Medicaid.

ENROLLMENT

This section analyzes enrollment patterns of CHIP children as well as Medicaid children (for comparison purposes) across multiple criteria, including growth year-to-year, average number of months of enrollment in the program, and distribution by age groups, delivery system of care, and urban/rural county status. A study of re-enrollment as well as comparisons of Indiana's uninsured children rate versus other states is also included.

How successful has Indiana's CHIP program been in terms of enrolling eligible children?

Indiana has been very successful in enrolling children into CHIP. The State met its objective to enroll 40,000 previously uninsured low-income children by September 30, 1999. Since meeting this objective, the State has made additional progress related to enrolling uninsured low-income children:

- There were 90,460 children who obtained health insurance through Indiana's Medicaid expansion portion of the program (CHIP Phase I) at some point during 2003. Of these, there were 47,375 children enrolled on December 31, 2003.

- There were 30,160 children who obtained health insurance through Indiana's State-designed portion of the program (CHIP Phase II) at some point during 2003. Of these, there were 16,767 children enrolled on December 31, 2003.

How does Indiana's child uninsurance rate compare to the U.S. average and nearby states?

Indiana's uninsurance rate for children age 0 through 18 is similar to the national average but at the higher end when compared to states in the region. Conversely, the percentage of children with employer-based coverage or self-insurance is the highest in the region (see Exhibit III.1 on the next page). This may explain why the percentage of children on Medicaid/CHIP in Indiana is the lowest in the region (with Minnesota). These results were also found in the Kaiser Commission study results shown in last year's report.

Exhibit III.1
Distribution of All Children Aged 0 to 18 by Insurance Status, 2001-2002

	U.S.	Indiana	Indiana Ranking Across 51 States*	Compared to other border/nearby states					
				Illinois	Kentucky	Michigan	Minnesota	Ohio	Wisconsin
Employer-based	59%	69%	9	66%	55%	67%	73%	69%	70%
Individual policies	4%	5%	8	4%	4%	2%	5%	3%	5%
Medicaid/CHIP	23%	15%	44	19%	25%	22%	15%	20%	20%
Other**	2%	0%	41	0%	5%	0%	0%	0%	0%
Uninsured	12%	11%	23	11%	11%	8%	6%	8%	5%

*Includes 50 states and District of Columbia
**Includes Medicare and insurance through military
Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured
Estimates based on pooled March 2003 Current Population Survey (U.S. Census Bureau)
Numbers are weighted to the 2000 Census

The findings shown above also were true for the sub-population of children in families at or below 200% of the federal poverty level. This is the same population that is eligible for CHIP or Medicaid in Indiana. The percentage of children at this family income level in Indiana is among the lowest in the nation (47th nationally). However, the uninsurance rate in Indiana for these children is the same as the national level of 21%. As in the population of all children, a higher proportion of children in families at or below 200% of the federal poverty level in Indiana have health insurance coverage through employer-based policies than their counterparts in other states.

Exhibit III.2
Distribution of Low-Income Children (Less than 200% of Poverty) Aged 0 to 18 by Insurance Status, 2001-2002

	U.S.	Indiana	Indiana Ranking Across 51 States*	Compared to other border/nearby states					
				Illinois	Kentucky	Michigan	Minnesota	Ohio	Wisconsin
Employer-based	28%	39%	2	34%	26%	32%	35%	33%	37%
Individual policies	4%	5%	14	3%	3%	2%	6%	3%	6%
Medicaid/CHIP	46%	34%	47	41%	48%	49%	42%	47%	45%
Other**	2%	1%	39	1%	6%	1%	0%	1%	1%
Uninsured	21%	21%	13	21%	17%	15%	17%	16%	10%

*Includes 50 states and District of Columbia
**Includes Medicare and insurance through military
Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured
Estimates based on pooled March 2003 Current Population Survey (U.S. Census Bureau)
Numbers are weighted to the 2000 Census

What is the growth rate in 2003 of the CHIP Program (Phases I and II)?

Similar to 2002, at the end of 2003 the children in CHIP accounted for 14% of all children under age 19 enrolled in Indiana's Hoosier Healthwise program. Enrollment in CHIP continues to increase each year, but is starting to grow at a slower pace than in the early years of the program. This is shown in the growth rate of 8% in 2003 as compared to 12% in 2002 and 8% in 2001 (see

Exhibit III.3 below). This combined growth in CHIP, however, is due almost solely to growth in CHIP Phase II.

Exhibit III.3
Total CHIP Enrollment & Annual Growth Rate

Year	CHIP Phase I	CHIP Phase II	Combined Enrollment	Combined Growth Rate
December, 2000	42,083	6,812	48,895	--
December, 2001	43,473	9,575	53,048	8%
December, 2002	46,616	12,695	59,311	12%
December, 2003	47,375	16,767	64,142	8%

Source: Dataprobe files through December 2003

Why is the enrollment between CHIP Phase I and CHIP Phase II so different?

Historically, children in the Phase I of CHIP were comprised of two unique groups—those children (all teenagers) that enrolled October 1, 1997 that were previously not eligible for Medicaid, and those children that enrolled on or after July 1, 1998 whose families earn between 100% and 150% of the federal poverty level. To be eligible for CHIP, the teenagers in the first group had to be born before October 1, 1983. The last of these children "aged out" of CHIP in September, 2002. These teenagers had been enrolled in Indiana's CHIP since its inception, comprising over 10,000 children in early 1998. Therefore, the larger starting enrollment in CHIP Phase I has always resulted in lower percentage growth increases in Phase I as opposed to CHIP Phase II which started with a few hundred enrollees in the beginning. Although CHIP Phase I enrollment was at its peak in mid-2003, the increase of 4,000 enrollees in CHIP Phase II in 2003 resulted in a sustained high growth rate of 32% in 2003 (see Exhibit III.4).

Exhibit III.4
Growth Rates of CHIP Members by Family Income Levels

Year	CHIP Members Phase I (100% - 150% of FPL)	CHIP Members Phase II (150% - 200% of FPL)	Growth Rate CHIP Phase I	Growth Rate CHIP Phase II
December, 2000	42,083	6,812	--	--
December, 2001	43,473	9,575	3%	41%
December, 2002	46,616	12,695	7%	33%
December, 2003	47,375	16,767	2%	32%

Source: Dataprobe files through December 2003

How does the age distribution of members in CHIP Phase I compare to the distribution in CHIP Phase II and Medicaid?

Exhibit III.5 on the next page shows how the variation in age distribution between CHIP Phase I and both CHIP Phase II and Medicaid is decreasing since 2001. As the population of teenagers that started in CHIP Phase I has aged out of the program, the distribution of children in CHIP Phase I has become more similar to CHIP Phase II and to Medicaid.

The one area that remains different between CHIP (both phases) and Medicaid is the population of children under age 1. As seen in the exhibit, the large majority of these children are in Medicaid. This is because children under age 1 with family income levels at or below 150% of the federal poverty level are eligible for Medicaid. By definition, therefore, none of these children are in CHIP Phase I since it is for enrollees with family incomes up to 150% of the poverty level. Likewise, this accounts for the small population of children under age 1 in CHIP Phase II. These would be children in families with incomes from 150%-200% of the poverty level. This difference in the population of infants accounts for differences in utilization and payment between CHIP and Medicaid as will be seen later in this section.

In calendar year 2003, the two CHIP programs had the largest share of children in the age 6-12 group while the Medicaid program had its large shares in the both the 1-5 and 6-12 age groups.

Exhibit III.5

Age Distribution of Children Age 0-18 by Program Type in 2001

Age Group	CHIP Phase I	CHIP Phase II	Medicaid
Age Under 1	0%	2%	11%
Age 1 to 5	12%	34%	37%
Age 6 to 12	46%	40%	35%
Age 13 to 18	42%	23%	18%

Age Distribution of Children Age 0-18 by Program Type in 2002

Age Group	CHIP Phase I	CHIP Phase II	Medicaid
Age Under 1	0%	2%	10%
Age 1 to 5	13%	34%	36%
Age 6 to 12	51%	40%	34%
Age 13 to 18	36%	24%	20%

Age Distribution of Children Age 0-18 by Program Type in 2003

Age Group	CHIP Phase I	CHIP Phase II	Medicaid
Age Under 1	0%	2%	10%
Age 1 to 5	14%	33%	35%
Age 6 to 12	54%	40%	34%
Age 13 to 18	33%	25%	21%

Source: Dataprobe files through December 2003

What is the distribution of enrollment by delivery system between CHIP Phase I, CHIP Phase II, and Medicaid members?

The Hoosier Healthwise program (both CHIP and Medicaid) has made a concerted effort in the past two years to enroll more children in the Risk-Based Managed Care (RBMC) delivery system. At this time, there are nine counties in the state where enrollment in RBMC is mandatory. Another four counties will become mandatory later in 2004. Under the RBMC system, members are enrolled with doctors who are affiliated with managed care entities. This system, in conjunction with the Primary Care Case Management (PCCM) delivery system, comprises Indiana's managed care program. The fee-for-service (FFS) portion of the program, however, remains relatively high, especially for CHIP Phase II. There are two primary reasons why children may be enrolled in the FFS portion of the program:

- The primary reason is that they are enrolled in the FFS system for a temporary period when first enrolling in Hoosier Healthwise before they have chosen a doctor (commonly referred to as the "fee-for-service window")

- They are affiliated with doctors in rural areas of the state where there is less managed care participation

Therefore, the findings in Exhibit III.6 reflect more of the fact that there are continually new members enrolling who are in FFS temporarily than that members with longer enrollment remain in FFS permanently.

Exhibit III.6
Percentage of Members Enrolled by Delivery System
Across Calendar Years 2001, 2002 and 2003

Year	Program Type	PCCM	RBMC	FFS
2001	CHIP Phase I	64%	18%	19%
	CHIP Phase II	58%	14%	28%
	Medicaid	60%	23%	16%
2002	CHIP Phase I	54%	30%	16%
	CHIP Phase II	46%	25%	29%
	Medicaid	48%	36%	16%
2003	CHIP Phase I	46%	38%	16%
	CHIP Phase II	41%	33%	26%
	Medicaid	40%	43%	18%

Source: Dataprobe files through December 2003

What are the Urban/Rural distribution patterns of CHIP Phase I and II versus Medicaid enrollment for children? Have they changed since last year?

The majority of beneficiaries in each program live in an urban area. The urban/rural distribution at the end of 2003 was the same as it has been since the end of 2000 with 81% of the CHIP population (Phase I and Phase II) and 86% of the Medicaid population residing in urban counties.

How does the average period of enrollment of members compare between CHIP Phase I, CHIP Phase II and Medicaid?

The average number of months children are enrolled in CHIP closely resembled that found for children in Medicaid in 2003 (see Exhibit III.7 below). Across the three programs, the average period of enrollment was 9-10 months for all age groups except for children under age one. This average appears low but has been the historical average seen across many states. Many children move between the Hoosier Healthwise programs. For example, children that were originally eligible for one of the CHIP phases may be determined eligible for Medicaid, and vice versa. For the purposes of the findings shown in Exhibit III.7, any months of enrollment for children across all of the Hoosier Healthwise programs (CHIP Phase I, CHIP Phase II, and Medicaid) were added together for each child. If a member moved across the programs during 2003, the child was included in only one program in the exhibit—namely, the program that they were enrolled in most recently.

Exhibit III.7
Average Period of Enrollment By Program and by Age Group (in months)
For Calendar Year 2003

	Under 1 Year	Age 1 - 5 Years	Age 6 - 12 Years	Age 13 and over
CHIP Phase I	not applicable	10.0	10.2	9.7
CHIP Phase II	7.5	9.4	9.5	9.3
Medicaid	6.9	10.4	10.3	9.1

Source: Dataprobe files through December 2003

How successful has Indiana been in retaining members in its CHIP program?

The study of retention and disenrollment conducted last year was completed again this year to study the impact of children who remain enrolled in Hoosier Healthwise after their first year in the program. The more recent study focused on those members that enrolled for the first time in either CHIP Phase I or Phase II between July 1, 2001 and June 30, 2002. These members were tracked from their initial enrollment to September 30, 2003 to determine:

- What percentage did not have a lapse in enrollment?
- What percentage had a lapse in enrollment but returned to the program later?
- What percentage dropped out of the program and did not return?

The study results shown in Exhibit III.8 below show similar findings with 40+ percent of members in CHIP Phase I and Phase II ending enrollment with no return. Although this rate seems high, last year we reported that data available nationally showed that this rate was not uncommon. Colorado reported disenrollment trends at 40 percent as well and New York experienced disenrollments which varied from 25 to 50 percent depending upon health plan (*Source: Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program, Mathematica Policy Research et al, February 26, 2003*).

Exhibit III.8
Enrollment Status After One Year of Eligibility
For CHIP Members Who Started Enrollment Between 7/1/00 and 6/30/01

Enrollment Status	Phase I Members	Phase II Members
No lapse in eligibility	44%	44%
Lapse in eligibility but returned	15%	13%
Eligibility ended with no return	41%	43%

Enrollment Status After One Year of Eligibility
For CHIP Members Who Started Enrollment Between 7/1/01 and 6/30/02

Enrollment Status	Phase I Members	Phase II Members
No lapse in eligibility	42%	38%
Lapse in eligibility but returned	17%	14%
Eligibility ended with no return	41%	48%

Note: Children who "aged out" of CHIP (turned age 19) were excluded from this analysis.

Source: Dataprobe files through December 2003

SERVICE UTILIZATION AND EXPENDITURES

As in prior years, an analysis of utilization and expenditures was completed to:

- Determine if members are using services at the overall expected rate (e.g. comparing utilization by children in CHIP Phase I, CHIP Phase II and the Medicaid program)
- Determine if there are differences in utilization patterns between the PCCM, RBMC and FFS delivery systems
- Determine if differences in per member per month expenditures between CHIP Phase I, CHIP Phase II and Medicaid children are a result of differing utilization patterns or the cost of services
- Determine if there are differences in expenditure patterns between age groups to better understand what may drive differences between the CHIP and Medicaid utilization and expenditures. Past evaluations found that the composition of the ages within a program (e.g. more teenagers in CHIP Phase I, more infants in Medicaid) often drove differences in both utilization and payment.

In addition to an introductory section that shows findings of utilization and expenditure trends overall, four subsections describe findings for four major types of services:

- Hospital services (including inpatient and outpatient)
- Physician services (including Primary Medical Providers and specialists)
- Pharmacy scripts
- Dental services

To capture utilization trends for specific time periods, EP&P evaluated utilization and expenditures based upon the date when the service was received, not when the service was paid for by the State. As a result, not all claims for the latter half of calendar year 2003 are represented because providers are still submitting claims for payment. This is especially true for hospital claims. Therefore, utilization and payment charts only reflect trends through the month of October 2003 so as not to artificially skew the findings.

As stated previously in Section I, the reporting of shadow claims (those encounters reported by managed care organizations that do not include payment data but provide utilization information) continue to be under-represented for the years analyzed in this report. [Information was collected from the OMPP in February 2004 representing services provided through December 2003.] Where the effects of this under-reporting are clearly influencing EP&P's findings, it is noted in the discussion.

Do utilization statistics indicate that CHIP members are accessing services?

Overall, CHIP members in the Phase I and Phase II portions of the program are accessing services at similar rates. The number of unique individuals enrolled in both CHIP phases for the PCCM and FFS delivery systems was measured and compared to the number of unique individuals that actually accessed services. This review was conducted separately for the following services—inpatient hospital, outpatient hospital, physicians serving as primary medical providers (PMPs), other physicians that are not PMPs (specialists), pharmacy, and dental services. The evaluation also compared these statistics to the children in the Medicaid program. Key findings from this analysis, as displayed in Exhibits III.9 – III.11 on the following pages, indicate:

- About 70% of all CHIP Phase I and II members accessed at least one of the services mentioned above in both 2002 and 2003. This is a slight improvement from what was reported in last year's report for users in 2001 and 2002.

- The results for children in Medicaid are slightly higher in both years (closer to 80%) but this is primarily due to the fact that the entire population of infants in Medicaid use one of these services and this population does not appear in CHIP.

- The most common service used in both CHIP and Medicaid is pharmacy services. About half of all enrollees in both programs had a pharmacy script in CY 2002 and 2003.

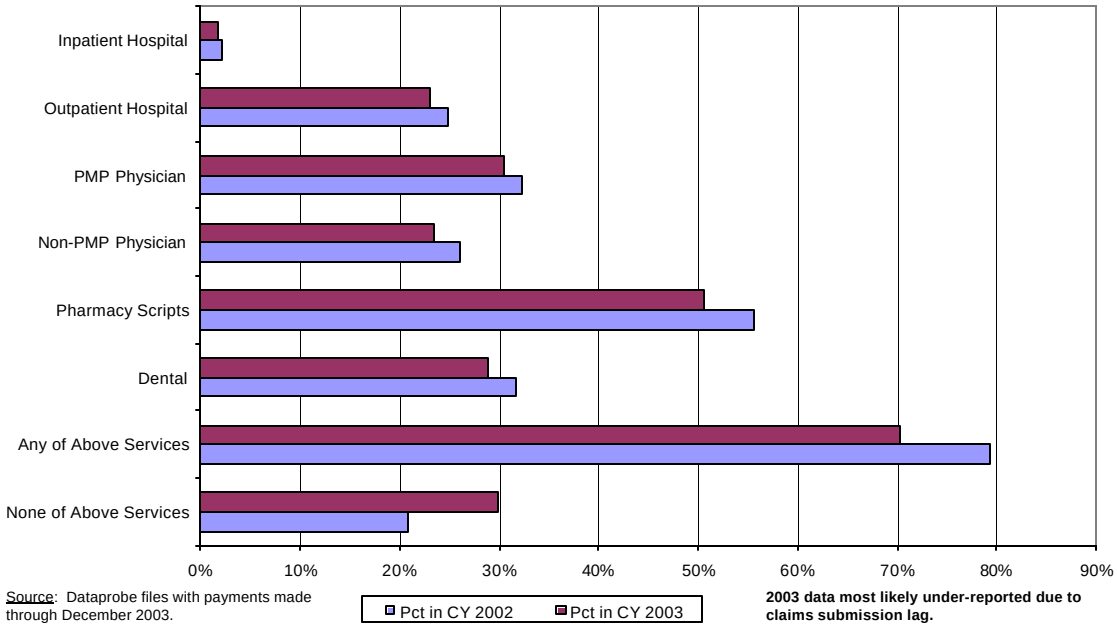
- Children in CHIP Phase II were slightly more likely to access physician services than their counterparts in CHIP Phase I but less likely than Medicaid children.

- Children in Medicaid are more likely to use inpatient and outpatient hospital services than children in CHIP. Again, this is mostly infants. When compared by age groups (1-5, 6-12, 13-18 years), utilization is similar between CHIP and Medicaid.

- Although it appears for both CHIP and Medicaid that there were lower percentages of children using services in CY 2003 than CY 2002, the figures for 2003 are most likely understated because not all claims have been submitted to the State yet.

It should be noted that there are other services available to CHIP members that have not been included in the analysis shown below (e.g. clinic services, inpatient psychiatric hospitalization, nursing facility, durable medical equipment). However, it is not anticipated that there would be a net increase of unique users of these services as it assumed that users of these "ancillary" services also have used one of the services represented in the exhibits.

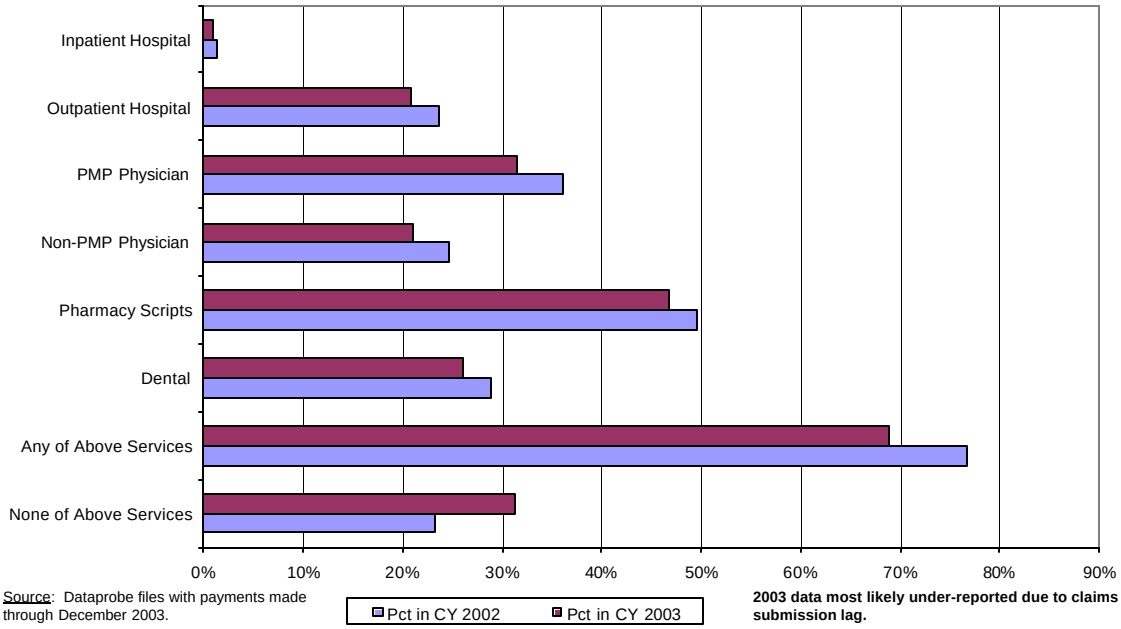
Exhibit III.9
Percent of CHIP Phase I Enrollees that Used Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: Dataprobe files with payments made through December 2003.

2003 data most likely under-reported due to claims submission lag.

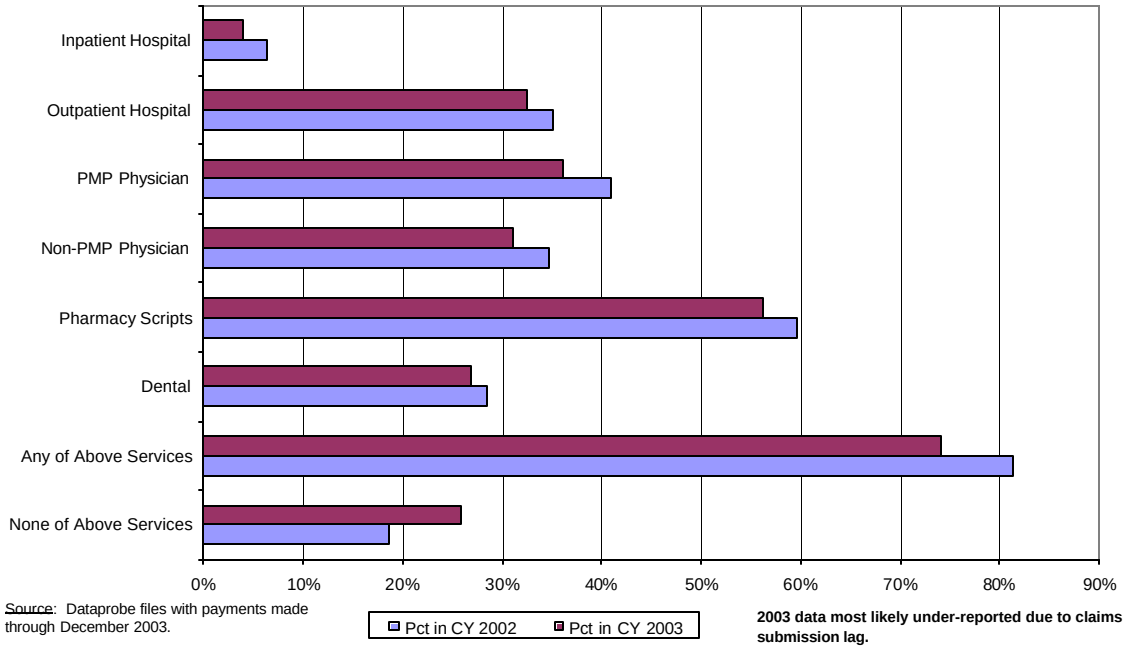
Exhibit III.10
Percent of CHIP Phase II Enrollees that Used Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: Dataprobe files with payments made through December 2003.

2003 data most likely under-reported due to claims submission lag.

Exhibit III.11
Percent of Medicaid Enrollees that Used Services
Based on Unique Number of Eligibles in the PCCM and FFS Delivery Systems



Source: Dataprobe files with payments made through December 2003.

2003 data most likely under-reported due to claims submission lag.

How do Indiana's utilization statistics for children compare to those of other states?

The percent of children in Indiana's Medicaid program that used key services was compared to other states' information to determine how Indiana's trends relate to peers and national averages. The states compared to Indiana are its border states and those in its CMS region—namely Illinois, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin. The data for comparison consisted of information that states are required to report to CMS (MSIS data) for the period of FFY 2001 (the most recent year available). Data reported for children in Medicaid was used as a proxy for CHIP data due to the variation in eligibility categories across the states' CHIP programs. However, as previously stated, the utilization of CHIP members in Indiana was similar to that of Medicaid children. The comparison across states showed that:

- When compared to its peers, Indiana's Medicaid children had a higher rate of utilization services for inpatient hospital and dental services than most states.

- For outpatient hospital, physician services and prescription drugs, Indiana's Medicaid children had a utilization rate that was in the middle or the same compared to some peers (Illinois, Kentucky, and Ohio) and higher than other peers (Michigan, Minnesota, Wisconsin).

- The information shown in Exhibit III.12 below is based upon date of payment in FFY 2001. However, the percentages shown for Indiana are similar to what was shown in last year's Annual Report for data conducted by EP&P for Indiana's Medicaid children based on date of service in calendar year 2001.

Exhibit III.12
Percent of Medicaid Child Enrollees that Used Services in FFY 2001
Based on Unique Number of Eligibles in Non-Managed Care Delivery Systems

	Inpatient Hospital Services	Outpatient Hospital Services	Physician Services	Prescribed Drugs	Dental Services
Indiana	9%	32%	56%	53%	33%
Illinois	5%	38%	56%	59%	43%
Kentucky	5%	35%	54%	57%	24%
Michigan	5%	11%	21%	21%	24%
Minnesota	3%	11%	19%	16%	6%
Ohio	12%	38%	56%	51%	20%
Wisconsin	3%	11%	9%	17%	14%

Source: MSIS Data for Federal Fiscal Year 2001, CMS Website, www.cms.hhs.gov/medicaid/msis

How do expenditures for CHIP children compare to Medicaid children?

Prior annual evaluation reports found that differences in expenditures for services between CHIP and Medicaid was usually based on different utilization patterns of members due to each program serving different age groups of children. For example, CHIP Phase I has experienced a higher percentage of total expenditures in pharmacy scripts due to the higher concentration of teenagers who were also found to have more expensive scripts on a per claim basis than younger children.

Expenditure patterns were reviewed for calendar years 2002 and 2003 in the PCCM and FFS delivery systems. Data from the RBMC delivery system is not included because payment data is not shown on RBMC shadow claims. The total expenditures for each service type were compared for both years within each program (CHIP Phase I, CHIP Phase II, and Medicaid) to determine if there have been shifts in expenditures between the services over the years. The percentage payments for each service type relative to total payments were also compared across the programs to see if one program spends more on a particular service than another program.

Relatively speaking, the distribution of payments in 2002 and 2003 (as measured by the percentage of payments to total payments for all services shown) were quite similar across services between CHIP Phase I and CHIP Phase II. Slight percentage differences occurred where CHIP Phase I experienced a higher percentage of expenditures for inpatient hospital and pharmacy scripts than CHIP Phase II. Other findings, as shown in Exhibit III.13 on the next page, include:

- The service accounting for the largest percentage of expenditures varied for each program. For CHIP Phase I, pharmacy scripts accounted for the greatest percentage of expenditures; for CHIP Phase II, dental services were greatest; for Medicaid, inpatient services were greatest.

- The higher percentage of payments for inpatient services in the Medicaid program is due to the number of infants in Medicaid that are not present in CHIP.

- Pharmacy and dental expenditures continue to grow as a higher percentage of total expenditures in CHIP Phase I, CHIP Phase II, and Medicaid.

- The percentage of expenditures for physician services (both PMP and non-PMP) as a percentage of the total has remained relatively constant within each program.

The reasons why expenditures have decreased for CHIP Phase I and for Medicaid are two-fold. One reason is because not all of the claims (and payments) were available to include in the 2003 totals at the time that this report was written. This primarily impacts inpatient hospital services. The primary reason, however, is because the population of children in the PCCM and FFS delivery systems declined from 2002 to 2003. For Medicaid, this population decreased 4%. For CHIP overall, this population remained flat but it actually reflects a decrease in the CHIP Phase I population and an increase in the CHIP Phase II population.

Exhibit III.13
Total PCCM and FFS Expenditures
For Calendar Years 2002 and 2003
By Program and Service Category

	CHIP PHASE I PROGRAM			
	Calendar Year 2002		Calendar Year 2003	
Category of Service	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total
Inpatient Hospital	$7,620,059	20.1%	$4,806,050	15.0%
Outpatient Hospital	$4,066,825	10.7%	$3,355,629	10.5%
PMP Physician	$2,343,733	6.2%	$1,961,632	6.1%
Non-PMP Physician	$2,999,228	7.9%	$2,322,440	7.3%
Pharmacy Scripts	$11,222,116	29.5%	$10,182,799	31.9%
Dental	$9,750,100	25.7%	$9,332,278	29.2%
Total	**$38,002,061**	**100.0%**	**$31,960,828**	**100.0%**

	CHIP PHASE II PROGRAM			
	Calendar Year 2002		Calendar Year 2003	
Category of Service	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total
Inpatient Hospital	$1,210,297	15.8%	$964,519	11.0%
Outpatient Hospital	$1,004,247	13.1%	$1,186,296	13.6%
PMP Physician	$647,391	8.4%	$759,657	8.7%
Non-PMP Physician	$746,565	9.7%	$788,768	9.0%
Pharmacy Scripts	$1,857,724	24.2%	$2,315,676	26.5%
Dental	$2,215,624	28.8%	$2,721,223	31.1%
Total	**$7,681,848**	**100.0%**	**$8,736,140**	**100.0%**

	MEDICAID PROGRAM			
	Calendar Year 2002		Calendar Year 2003	
Category of Service	Total Expenditures	Percent of Total	Total Expenditures	Percent of Total
Inpatient Hospital	$102,428,984	31.4%	$65,761,509	24.0%
Outpatient Hospital	$35,225,269	10.8%	$30,885,114	11.3%
PMP Physician	$25,883,332	7.9%	$22,838,311	8.3%
Non-PMP Physician	$26,575,653	8.1%	$20,522,439	7.5%
Pharmacy Scripts	$74,957,662	23.0%	$71,768,929	26.2%
Dental	$61,074,928	18.7%	$61,873,126	22.6%
Total	**$326,145,828**	**100.0%**	**$273,649,428**	**100.0%**

Notes

1. Capitation payments made to managed care entities are not included in the above totals.
2. Other services representing a small portion of expenditures are not included above.
3. The totals for the Medicaid group represent expenditures for the children in Medicaid only.
4. All expenditures are categorized by calendar year based upon dates of service.
5. Calendar year 2003 expenditures are artificially low due to a "lag" in claims processing at year-end.

Source: Dataprobe files with payments made through December 2003

How do expenditures compare between the RBMC delivery system and the PCCM/FFS delivery systems for children in CHIP and Medicaid?

Among the purposes of the RBMC delivery system is to: (1) provide a medical home for Hoosier Healthwise members so that better and more coordinated care can be provided; (2) improve the quality of services provided; and (3) gain cost efficiencies by obtaining services from providers in a cost effective manner. The monthly capitation payments made to managed care organizations (MCOs) that perform the service functions for children in the RBMC delivery system were compared to the payments made on a claim-by-claim basis to providers who perform services for children in the PCCM and FFS delivery systems. This is especially important to study since the state is continuing to encourage more enrollment in the RBMC delivery system.

The payment and expenditure analyses presented in Exhibits III.14-III.16 do not include dental service expenditures. This is because dental services are "carved out" of the RBMC delivery system, meaning that the MCOs are not responsible for providing this service and therefore their payment does not include the cost to provide this service.

Exhibit III.14 that appears on the next page shows the total payments made to MCOs for children in CHIP (Phases I and II combined) and Medicaid during state fiscal year 2003. This time period was selected to avoid any lag in payments being made for both claims and capitation payments. Payments are made to MCOs on a monthly basis for each member and not on a claim-by-claim basis. The exhibit also shows the payments for services made to PCCM and FFS providers for major services (hospital, physician, and pharmacy). Because these services are paid for each type of service uniquely, a per member per month (PMPM) amount can also be computed for each service. The sum of the PMPMs for each service results in the total PMPM for the PCCM/FFS population that is compared to the monthly capitation payment made for the RBMC population.

The information on this exhibit shows two key findings:

- Payments on a per member per month basis are lower for children in CHIP than they are for children in Medicaid in both the RBMC delivery system and the PCCM/FFS delivery systems.

- Payments on a per member per month basis are lower for children in the PCCM/FFS delivery systems than in the RBMC delivery system for both CHIP and Medicaid children.

Exhibit III.14
Payment Comparison Across Hoosier Healthwise Delivery Systems
For State Fiscal Year 2003 (July 2002-June 2003)
By Program and Service Category

	CHIP Phases I and II	Medicaid Children
Total RBMC Payments	**$19,241,003**	**$213,037,151**
Total PCCM and FFS Payments	**$29,990,507**	**$243,120,158**
Inpatient Hospital	$7,098,905	$90,410,001
Outpatient Hospital	$4,766,490	$33,291,252
PMP Physician	$2,839,202	$24,981,837
Non-PMP Physician	$3,588,567	$24,503,678
Pharmacy Scripts	$11,697,343	$69,933,390

RBMC Member Months	**266,073**	**2,160,770**
PCCM and FFS Member Months	**456,053**	**2,821,508**

RBMC Payments Per Member Per Month	**$72.31**	**$98.59**
PCCM and FFS Payments Per Member Per Month	**$65.76**	**$86.17**
Inpatient Hospital	$15.57	$32.04
Outpatient Hospital	$10.45	$11.80
PMP Physician	$6.23	$8.85
Non-PMP Physician	$7.87	$8.68
Pharmacy Scripts	$25.65	$24.79

Notes

1. Dental services are not included in the above totals.
   This is because dental services are not included in the capitation payments.
2. Other services representing a small portion of expenditures are not included above.
3. The totals for the Medicaid group represent expenditures for the children in Medicaid only.
4. All payments are categorized based upon date of service, not date of payment.

Source: Dataprobe files with payments made through December 2003

How do expenditures compare between the RBMC delivery system and the PCCM/FFS delivery systems for children in CHIP and Medicaid when children under age 1 are excluded?

Exhibit III.15 on the following page shows the findings in the same format as those shown in Exhibit III.14. This time, children under age 1 have been removed from both the CHIP and Medicaid totals. As discussed previously, the Medicaid program has almost all of the children in this category. Children under age one are also the most costly to the state on a PMPM basis due to their hospitalization at birth as well as numerous physician visits in the first year of life. By excluding this group, the results found in the previous exhibit have changed as follows:

- Payments on a PMPM basis are lower for children in CHIP than they are for children in Medicaid in the PCCM/FFS delivery systems. This difference, however, is primarily accounted for in one service area—inpatient hospital services.

- Payments on a PMPM basis are slightly higher for children in CHIP than for children in Medicaid in the RBMC delivery system, after the children under age one are removed.

- Payments on a PMPM basis are lower for children in the PCCM/FFS delivery systems than in the RBMC delivery system for CHIP children. However, Medicaid RBMC enrollees cost the same to the state as the PCCM/FFS enrollees.

Exhibit III.15
Payment Comparison Across Hoosier Healthwise Delivery Systems
For State Fiscal Year 2003 (July 2002-June 2003)
By Program and Service Category
Children Under Age 1 Excluded

	CHIP Phases I and II	Medicaid Children
Total RBMC Payments	**$19,143,598**	**$135,593,738**
Total PCCM and FFS Payments	**$29,488,070**	**$180,729,126**
Inpatient Hospital	$6,730,451	$51,715,060
Outpatient Hospital	$4,736,785	$28,055,648
PMP Physician	$2,788,222	$16,216,093
Non-PMP Physician	$3,557,018	$19,510,881
Pharmacy Scripts	$11,675,594	$65,231,445

RBMC Member Months	**265,290**	**1,923,080**
PCCM and FFS Member Months	**453,823**	**2,552,860**

RBMC Payments Per Member Per Month	**$72.16**	**$70.51**
PCCM and FFS Payments Per Member Per Month	**$64.98**	**$70.79**
Inpatient Hospital	$14.83	$20.26
Outpatient Hospital	$10.44	$10.99
PMP Physician	$6.14	$6.35
Non-PMP Physician	$7.84	$7.64
Pharmacy Scripts	$25.73	$25.55

Notes

1. Dental services are not included in the above totals.
   This is because dental services are not included in the capitation payments.
2. Other services representing a small portion of expenditures are not included above.
3. The totals for the Medicaid group represent expenditures for the children in Medicaid only.
4. All payments are categorized based upon date of service, not date of payment.

Source: Dataprobe files with payments made through December 2003

Is the reason that CHIP children in the PCCM/FFS delivery systems are less costly than CHIP children in the RBMC delivery system because they are receiving fewer services?

No. In fact, the data suggests that children in the PCCM/FFS delivery systems receive more services than their counterparts in the RBMC delivery system. However, this finding is not conclusive due to the ongoing issue surrounding the reporting of RBMC shadow claims. It may not be that fewer services are being performed in the RBMC delivery system; merely, not all of these services have been reported.

From the data that is available, the utilization per 1,000 PCCM/FFS members was compared against the utilization per 1,000 RBMC members. Unlike in the prior exhibits, utilization on shadow claims is reported for each service separately. Therefore, comparisons can be made at the service level when payments are not being considered.

Exhibit III.16 shows the utilization per 1,000 members for inpatient hospital, outpatient hospital, PMP physician, Non-PMP physician, pharmacy and dental services. The only instance where the utilization is higher for RBMC members is for dental services. Ironically, this service is not covered by the MCOs.

For comparison purposes, the payments per member per month that were shown previously in Exhibit III.14 for CHIP children are displayed again to show the relationship between utilization and payments. The data suggests that the MCOs are not providing as many services to CHIP members as the PCCM/FFS providers. Yet, the state is paying more for these services.

Exhibit III.16
Comparison of Utilization and Payments for CHIP Members
For State Fiscal Year 2003 (July 2002-June 2003)
By Service Category

	CHIP Phase I & II	
Claims Per 1,000 Members	**PCCM and FFS Combined**	**RBMC**
Inpatient Hospital*	21	3
Outpatient Hospital	83	61
PMP Physician	165	134
Non-PMP Physician	124	91
Pharmacy Scripts	463	307
Dental	107	124
Payments Per Member Per Month**	**$65.76**	**$72.31**

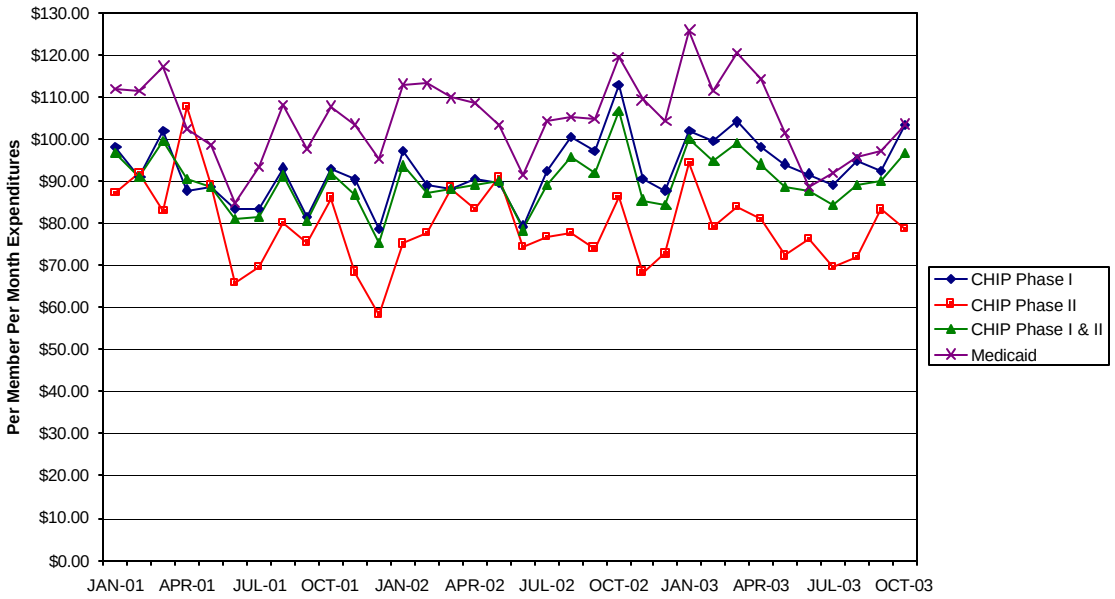
*Inpatient Hospital data reflected as days per 1,000 rather than claims per 1,000.
**Payments Per Member Per Month are exclusive of dental payments in both categories.

Source: Dataprobe files with payments made through December 2003

How do the overall per member per month expenditures differ between CHIP Phase I and CHIP Phase II?

In the last three years, the PMPM between children in CHIP Phase I and CHIP Phase II has gotten further apart (see Exhibit III.17 below). Although fluctuations are reported on a month-to-month basis, the average PMPM for children in CHIP Phase II has remained steady at $79-$80 in the last three years. Meanwhile, the PMPM in CHIP Phase I has grown from an average of $89 in 2001 to $97 in 2003. However, when compared to children in Medicaid, the PMPM for children in CHIP Phase I and Phase II has always been lower. As discussed previously, this is due to the population of children under age one in Medicaid.

Exhibit III.17
Per Member Per Month Expenditures (All Major Services)
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

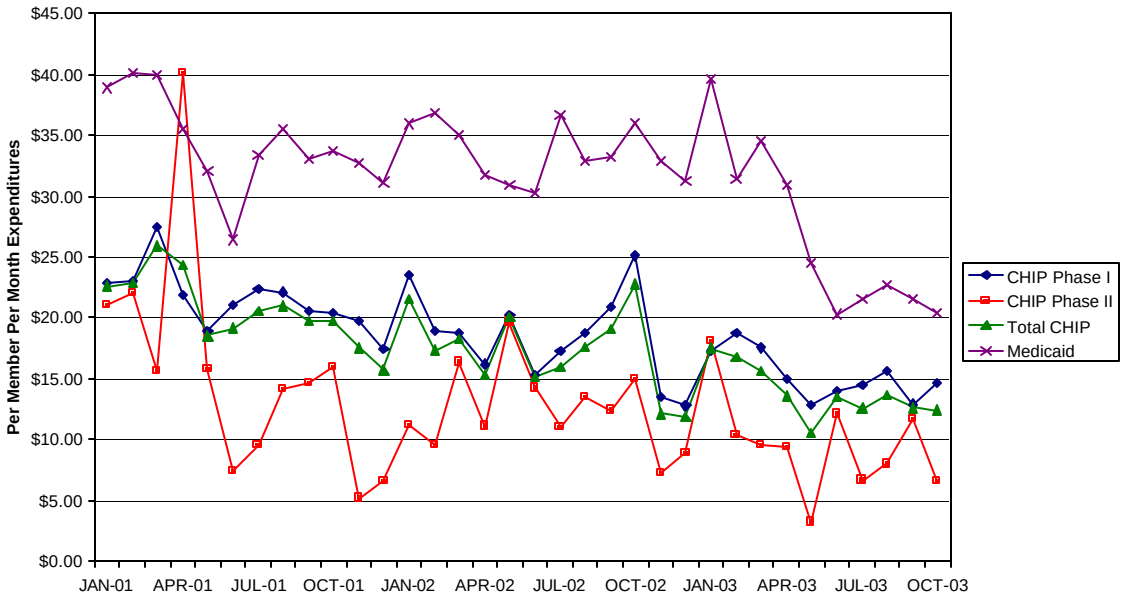
HOSPITAL SERVICES

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II and Medicaid for inpatient and outpatient hospital services? Do expenditures relate to utilization trends?

The PMPM findings for inpatient hospital services on a month-to-month basis are the most volatile of all of the services studied due to the lower volume of total claims. Nonetheless, Exhibit III.18 shows that there is a trend in the PMPM expenditures when compared against the different programs. In the last three years, the PMPM for inpatient hospital services for Medicaid children has historically been $10-$15 higher per month than the PMPM for the CHIP program (Phase I and II combined). This is related to the higher utilization of inpatient hospital services among Medicaid members, as shown on the next page in Exhibit III.19.

Among CHIP members, CHIP Phase II PMPM and utilization for this service has remained below the same monthly statistics for members in CHIP Phase I.

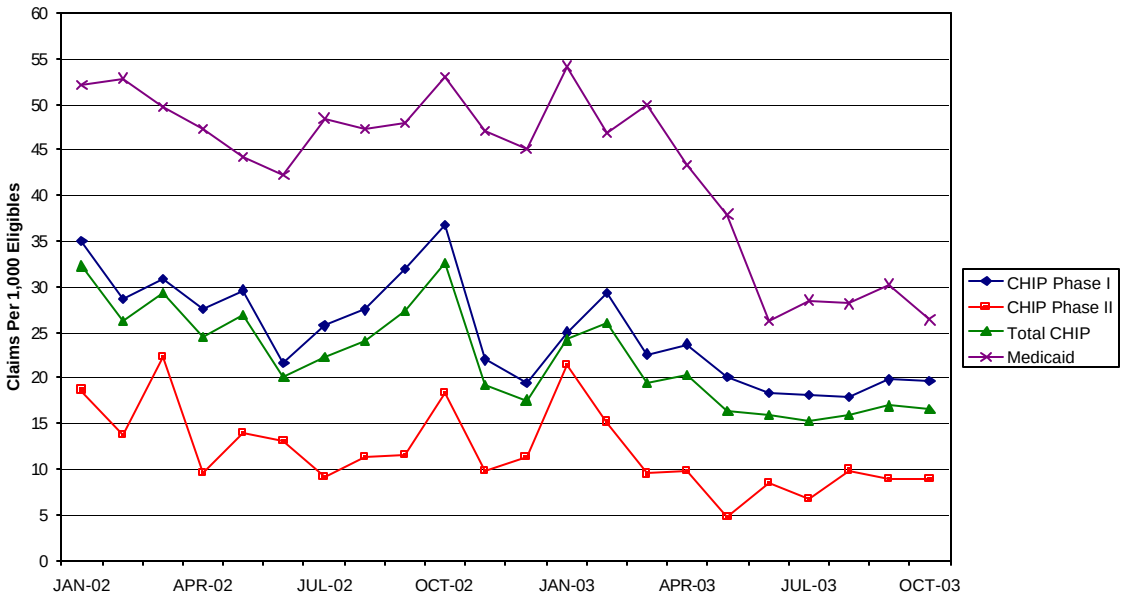
Exhibit III.18
Inpatient Hospital Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

A common method of measuring utilization is on a "per 1,000 eligibles" basis. This allows for comparisons between populations of varying sizes, as is the case between CHIP and Medicaid and further between CHIP Phase I and CHIP Phase II. For inpatient hospital services, it is often customary to measure utilization on a days per 1,000 basis instead of a claims per 1,000 basis. The higher utilization shown in Exhibit III.19 for Medicaid along with the PMPM factors shown in Exhibit III.18 can be directly attributed to the utilization of the children under age one in Medicaid, since the data includes their hospitalization at birth. When adjusted for age, the results between CHIP and Medicaid are quite similar.

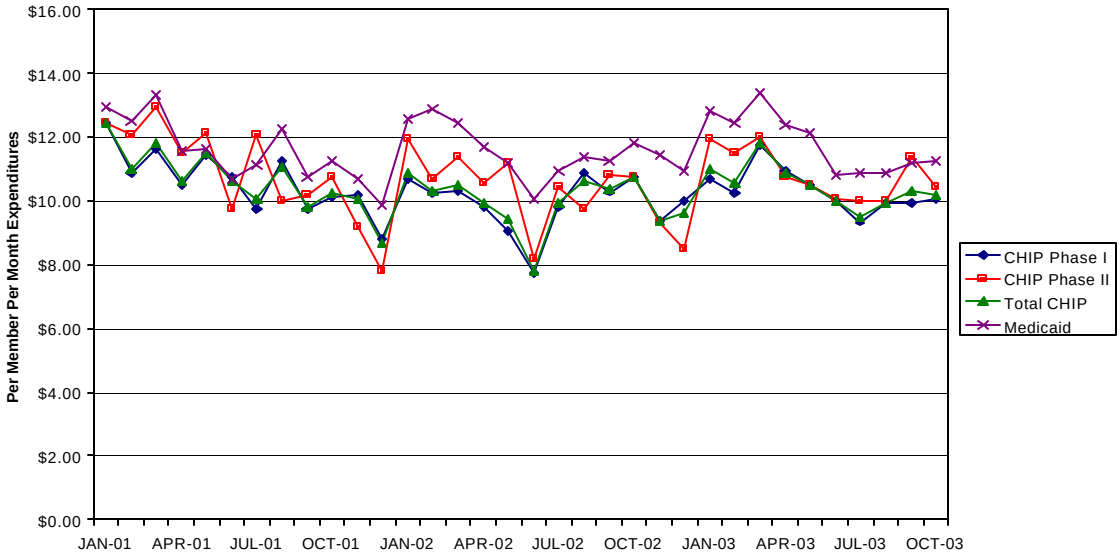
Exhibit III.19
Inpatient Hospital Days Per 1,000 Eligibles (PCCM and FFS Delivery Systems)
For CHIP Phase I, CHIP Phase II and Medicaid
January 2002 - October 2003



Source: Dataprobe files available through December 2003. Shadow claims (RBMC delivery system) excluded because they were

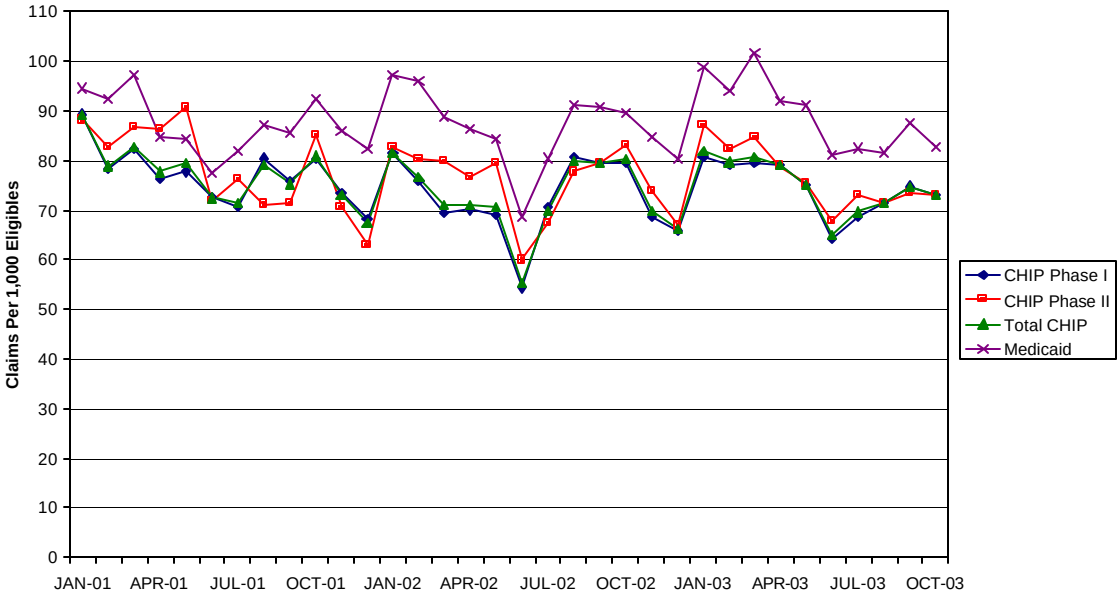
In contrast, outpatient hospital PMPM expenditures have been more stable for all programs and are more closely aligned between $8 and $13 per member per month. The Medicaid PMPMs have been slightly higher over the past three years when compared to CHIP, and CHIP Phase II tends to be slightly higher than CHIP Phase I (see Exhibit III.20 on the next page). The PMPM factors appear to be driven by utilization, as the utilization of services per 1,000 members follows the same patterns as the PMPM (see Exhibit III.21 on the next page). Medicaid utilization is slightly higher than CHIP overall, and CHIP Phase II has utilization slightly higher than CHIP Phase I. This contrasts with inpatient hospital where CHIP Phase I members had higher utilization and higher PMPMs than CHIP Phase II.

Exhibit III.20
Outpatient Hospital Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

Exhibit III.21
Outpatient Hospital Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files available through December 2003. Shadow claims (RBMC delivery system) included.

How does the utilization of inpatient and outpatient hospital services for CHIP members compare across the three delivery systems?

Service utilization for CHIP members (Phase I and Phase II combined) across the three types of delivery systems—PCCM, RBMC and FFS—was examined to determine any trends. As we found last year, CHIP members in the FFS delivery system are using more inpatient hospital services than members in the PCCM or RBMC delivery systems. This may reflect the fact that higher proportions of new members (who are temporarily in the fee-for-service "window") are often in greater need of hospital services than longer-term enrollees. Although it is expected that not all of the utilization in late 2003 is present in these findings due to the claims submission lag, the RBMC utilization remained significantly under-reported for the three-year period of CY 2001 to CY 2003 studied.

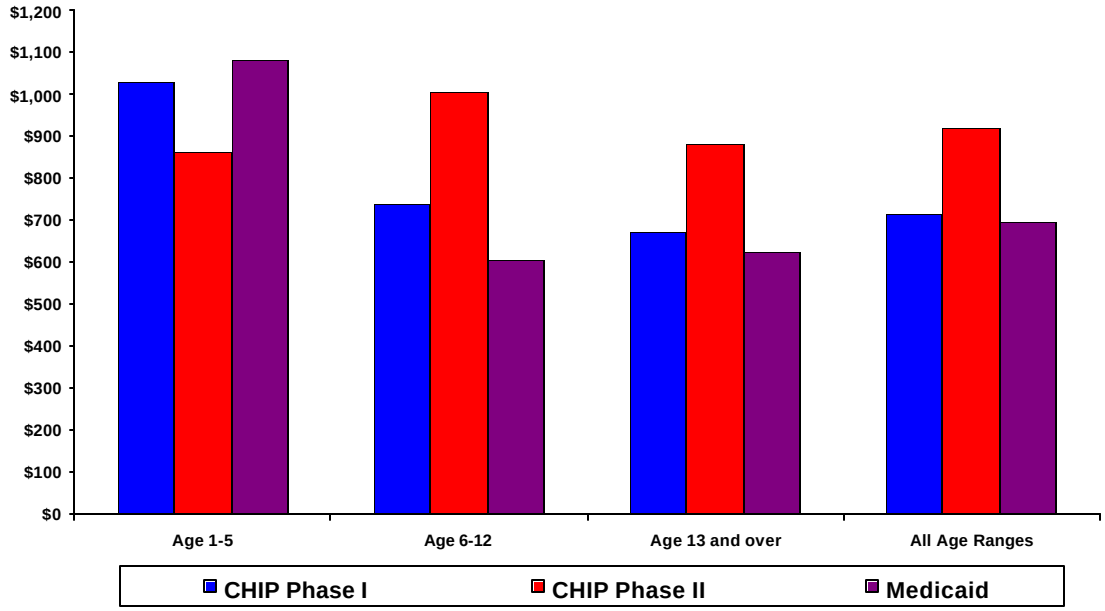
For outpatient services, it was found that utilization for PCCM members actually outpaced that for members in the RBMC and FFS systems. Reporting of RBMC shadow claims appeared to be more complete for this service.

Are there variations between the costs of hospital services for CHIP and Medicaid members by age group?

For inpatient hospital services in 2003, the payment per day for CHIP Phase I members overall ($715) was very similar to Medicaid ($723). These results were 20% lower than the average payment per day for CHIP Phase II members ($902). However, this difference could be mostly attributed to the lower claim volume in CHIP Phase II (CHIP Phase I members utilized six times as many days as CHIP Phase II members). This trend also held true across major age groups, except for one group. Among children ages 1-5, the average payment per day was actually lower for CHIP Phase II children than for CHIP Phase I or Medicaid children (see Exhibit III.22 on the next page).

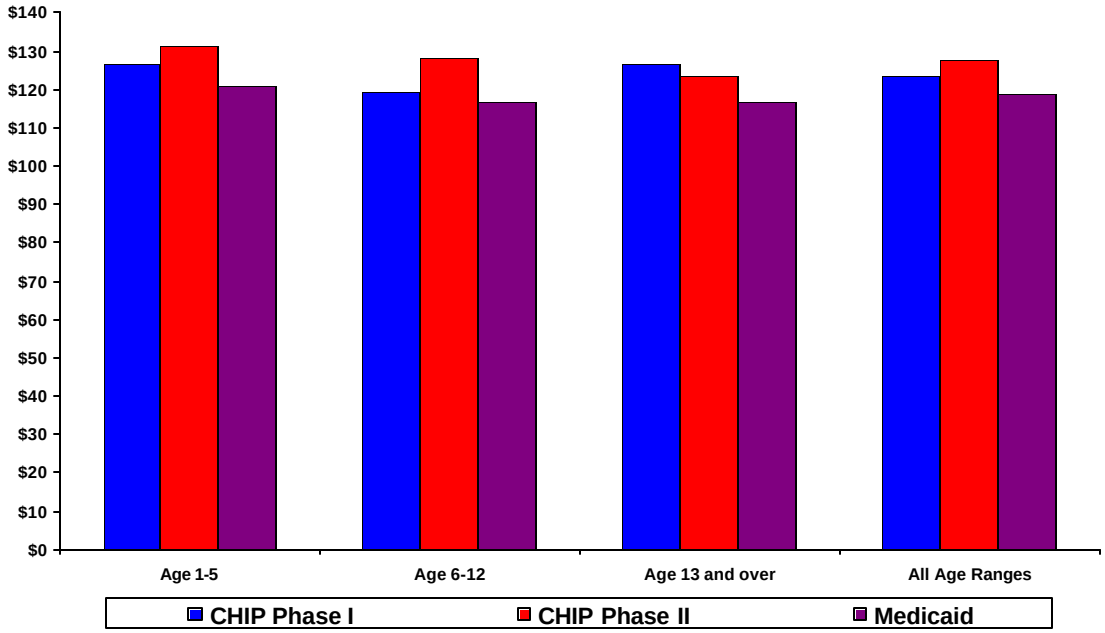
For outpatient hospital services in 2003, there is very little difference in the average payment per claim between CHIP and Medicaid or between the age groups (see Exhibit III.23 on the next page). Overall, the average payment per claim is approximately $120-$130 for all three programs.

Exhibit III.22
Inpatient Hospital Average Paid Per Day
For Dates of Service in Calendar Year 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

Exhibit III.23
Outpatient Hospital Average Paid Per Claim
For Dates of Service in Calendar Year 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

PHYSICIAN SERVICES

For this analysis, services provided by physicians to CHIP members were classified into two major categories: services provided by a PMP (Primary Medical Provider) and services provided by a physician that is not classified as a PMP. A PMP serves as the coordinator of care for a child in CHIP or Medicaid. In the PCCM delivery system, these PMPs are paid a monthly administrative fee to assume this responsibility. PMPs may include General Practitioners, General Pediatricians, Family Practitioners, OB/GYNs, and General Internists. Physicians with these specialties who choose to assume this role are assigned a special PMP ID by the state. However, there may be other physicians in a group practice that have these specialties but do not have a PMP ID.

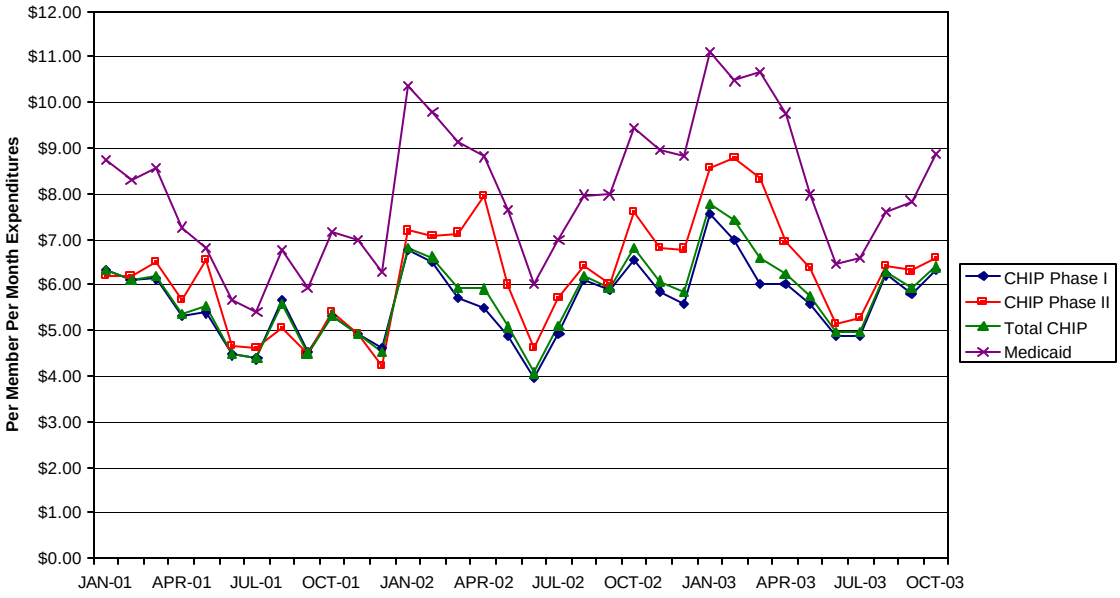
For the purposes of this study, physicians with the five specialties listed above are considered PMPs, regardless of whether or not the state has assigned them a PMP ID. All other types of physicians are classified into the "non-PMP" group, more commonly known as specialists.

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II and Medicaid for PMP and non-PMP physicians? Do expenditures relate to utilization trends?

There appears to be some seasonality in the utilization of PMP services, with the winter months showing the highest utilization. This is also driving higher PMPM expenditures in the winter months. Within a program, the pattern for both PMPM expenditures and utilization has been consistent in the past three years. However, there are variances between the programs, as shown in Exhibits III.24 and III.25 on the next page. The expenditures per member per month are the highest in Medicaid and usually range from $6-$11. In CHIP Phase II, they are slightly lower with a range of $5-$8 and they are the lowest in CHIP Phase I at $4-$7.

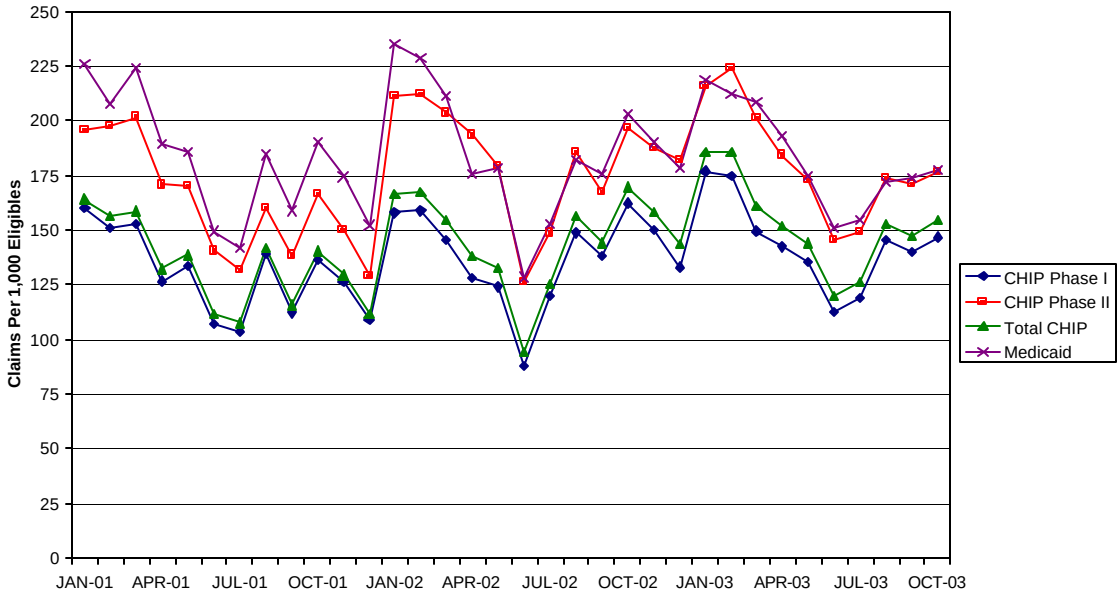
Utilization trends for PMP services follow similar patterns. It should be noted, however, that the CHIP Phase II children have utilization at the same rate as children in Medicaid yet their PMPM expenditures are lower. This means that the average payment per claim paid for CHIP Phase II children is lower than that paid for services to Medicaid children.

Exhibit III.24
PMP Physician Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

Exhibit III.25
PMP Physician Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files available through December 2003. Shadow claims (RBMC delivery system) included.

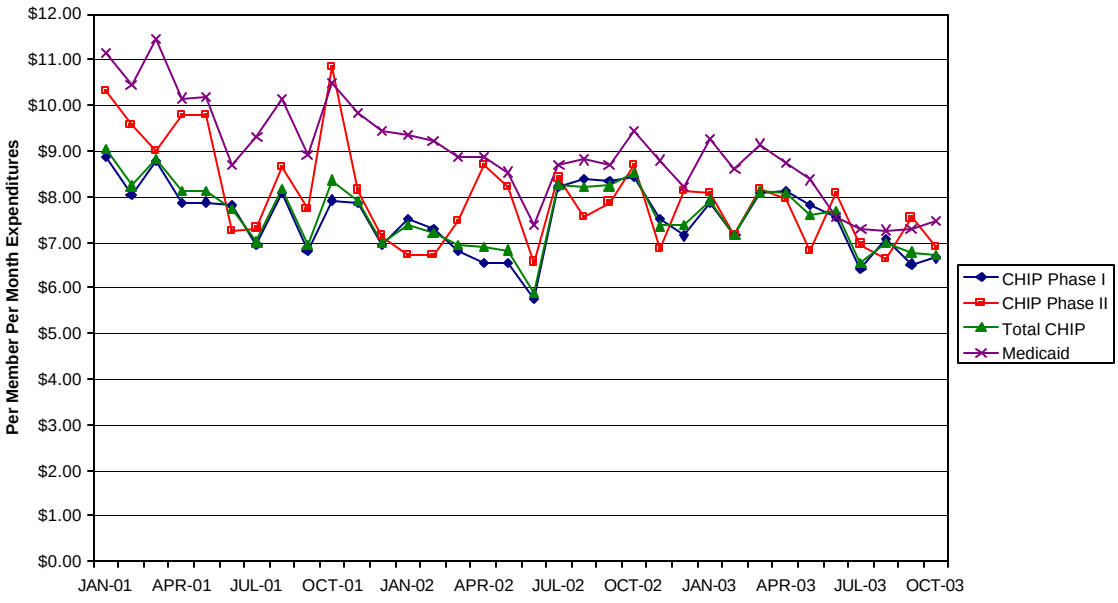
For non-PMP physicians, the differences between Medicaid and CHIP are the same as for PMP physicians. The Medicaid PMPM has been $8-$11 per month whereas the CHIP Phase II PMPM has been $7-$9 per month and CHIP Phase I is usually $6-$8 per month (see Exhibit III.26).

Also, it should be noted that the State is paying about $2 more per member per month on non-PMP services than for PMP services. This may be attributable to the types of specialist physicians that are included in the non-PMP group.

Utilization for non-PMP services does not show the seasonality that was seen in the PMP utilization (see Exhibit III.27 on the next page). Although the utilization patterns across the programs are like the patterns seen for PMP utilization—Medicaid and CHIP Phase II utilization about the same and higher than CHIP Phase I utilization—the differences are not as great for non-PMP utilization.

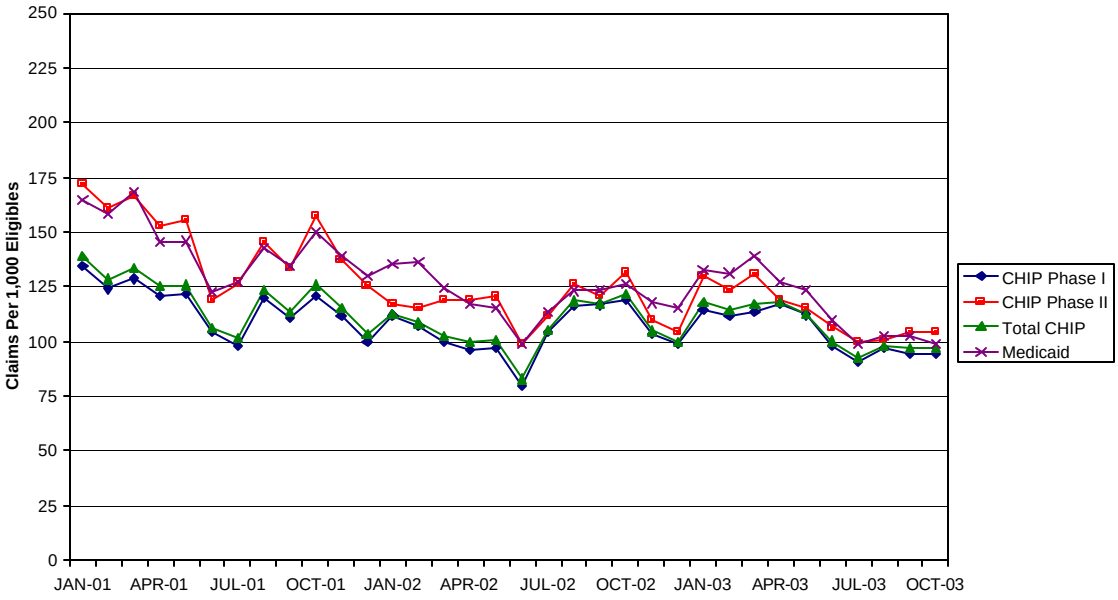
As expected, utilization of non-PMPs is lower than that of PMPs for both CHIP and Medicaid.

Exhibit III.26
Non-PMP Physician Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

Exhibit III.27
Non-PMP Physician Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files available through December 2003. Shadow claims (RBMC delivery system) included.

How does the utilization of physician services for CHIP members compare across the three delivery systems?

For PMP services, utilization during calendar years 2001-2003 was reported to be much higher for the population of children in PCCM (140-200 claims per 1,000) than in RBMC (100-140 claims per 1,000) or FFS (80-120 claims per 1000). It should be noted that for children in the FFS delivery system, this is usually a short-term stay until they move into the PCCM or RBMC systems, so the data for FFS utilization is skewed. It is still a concern, as reported in prior years, if the results shown for the RBMC population are accurate. That is, the lower utilization trend for the RBMC population may actually just be a lack of reporting on behalf of the MCOs rather than actual lower utilization.

For non-PMP services, utilization across all delivery systems was 80-120 claims per 1,000 members each month from 2001-2003. Once again, however, the utilization for PCCM members was consistently at the higher end of this range whereas the utilization for RBMC and FFS members was at the lower end of this range.

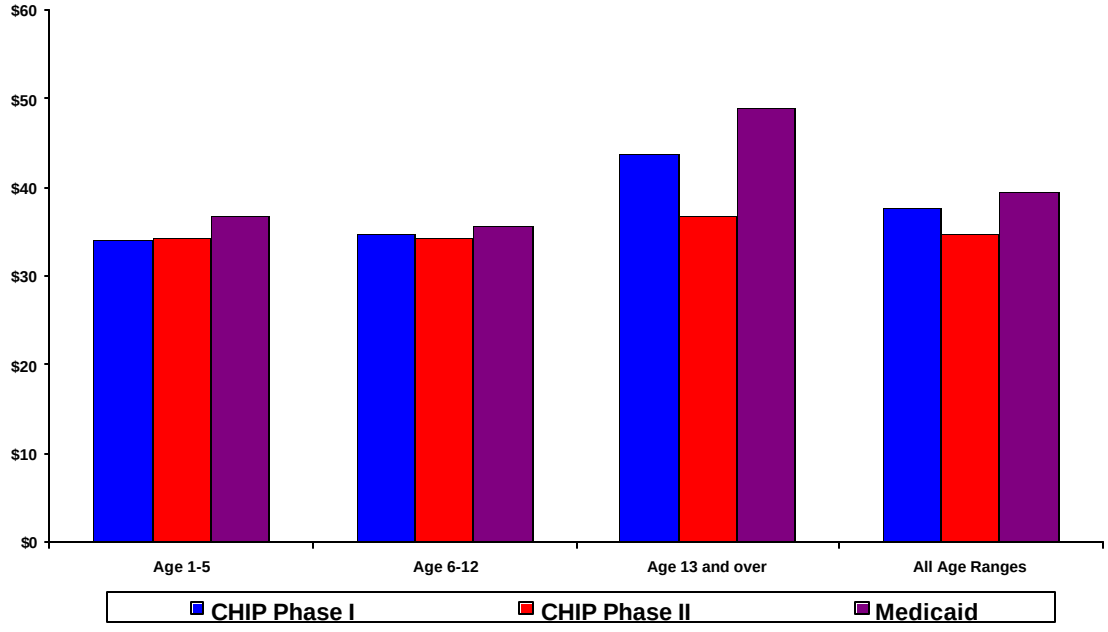
Are there variations between the costs of physician services for CHIP and Medicaid members by age group?

There was little difference found in the average paid per claim for PMP services among younger children in 2003 between CHIP and Medicaid. For teenagers, both CHIP Phase I and Medicaid had higher average payments per claim than CHIP Phase II (see Exhibit III.28). There has been very little change in the average paid per claim (all ages) for PMP services between the years 2001 and 2003 for CHIP or Medicaid.

The average payment per claim for non-PMP physicians was more than 50% higher than the average payment per claim for PMP physicians in CHIP Phase I and Phase II. For Medicaid children, the difference was more than 30% higher. This is most likely due to the specialty nature of services provided by non-PMPs that are usually outside of well-child and other routine visits.

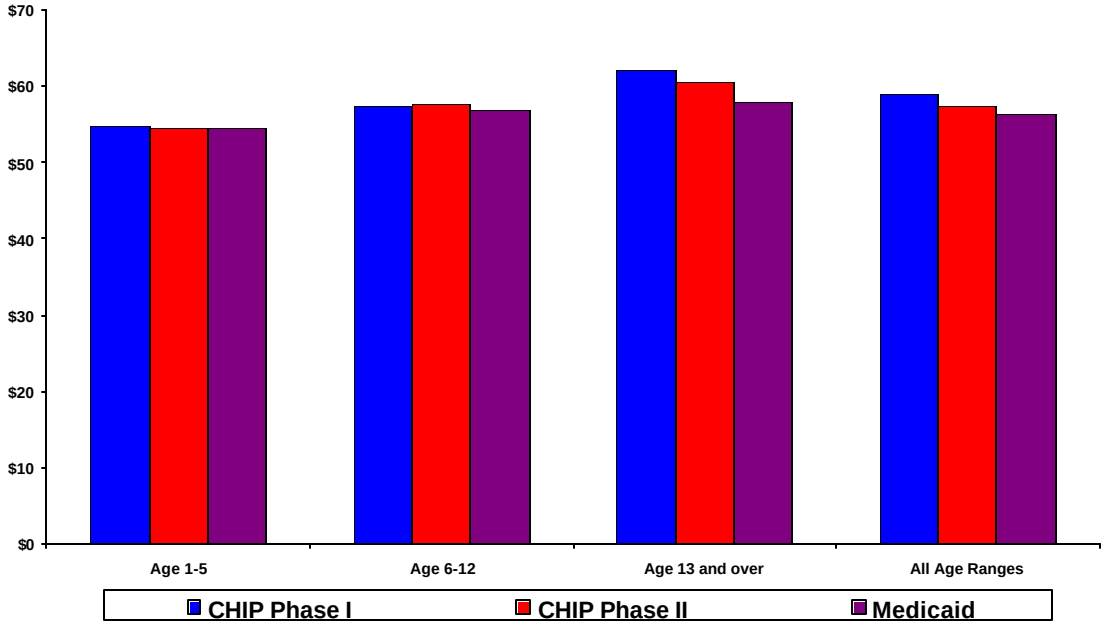
Exhibit III.29 (on the next page) shows that within the non-PMP claims, however, there was little variation between age groups or between the programs. Payments usually were within the range of $55 to $60 per claim. Payments for services to teenagers were only slightly higher than those for other children.

Exhibit III.28
PMP Physician Average Paid Per Claim
For Dates of Service in Calendar Year 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

Exhibit III.29
Non-PMP Physician Average Paid Per Claim
For Dates of Service in Calendar Year 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

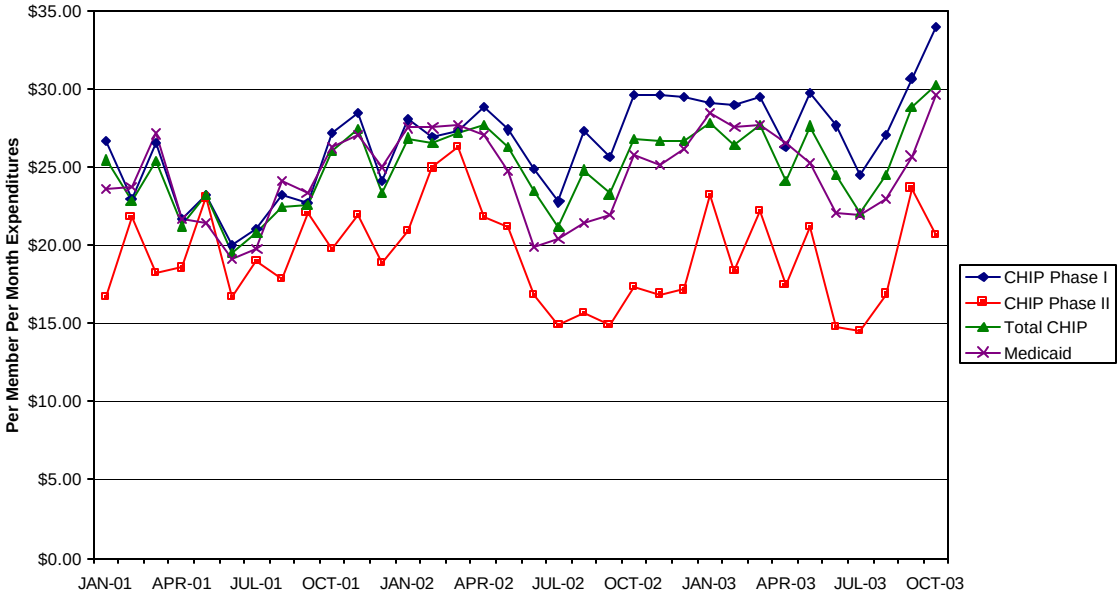
PHARMACY SERVICES

The average payment per pharmacy claim remained flat at approximately $47 for both CHIP Phase II and Medicaid from calendar year 2002 to 2003. For CHIP Phase I, however, the average payment per pharmacy claim increased $5 (9%) during this time period. As reported in 2002, more than half of the children in CHIP in 2003 had a prescription. Therefore, the increase in pharmacy expenditures in CHIP is attributable more to the growth in members in the program itself. The state has been able to maintain utilization levels and per unit costs of pharmacy scripts for children in the last three years.

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II and Medicaid for PMP and non-PMP physicians? Do expenditures relate to utilization trends?

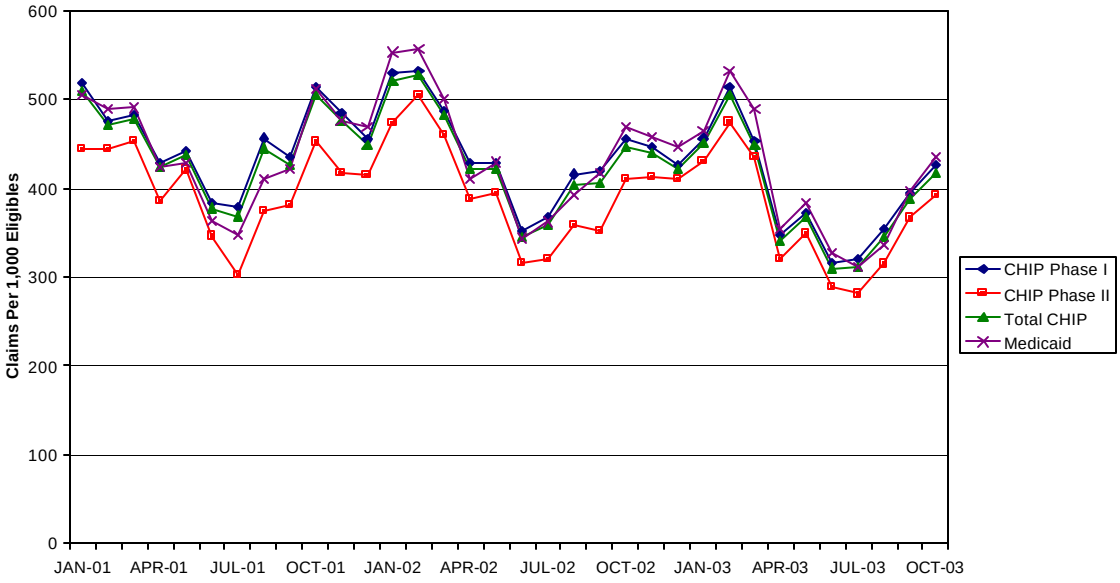
As seen in PMP utilization, there is some seasonality in utilization of pharmacy scripts which impacts the monthly PMPM expenditures. But CHIP Phase I and Medicaid PMPMs have remained between $20 and $30 in the last three years, while the PMPM for CHIP Phase II has been consistently lower, between $15 and $25 per month (see Exhibit III.30 on the following page). However, the fact that utilization is so similar between both CHIP Phases and Medicaid yet the CHIP Phase II PMPMs are lower indicates that the average payment per claim for CHIP Phase II is lower than that of the other programs. The utilization trends are shown on the next page in Exhibit III.31.

Exhibit III.30
Pharmacy Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

Exhibit III.31
Pharmacy Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003

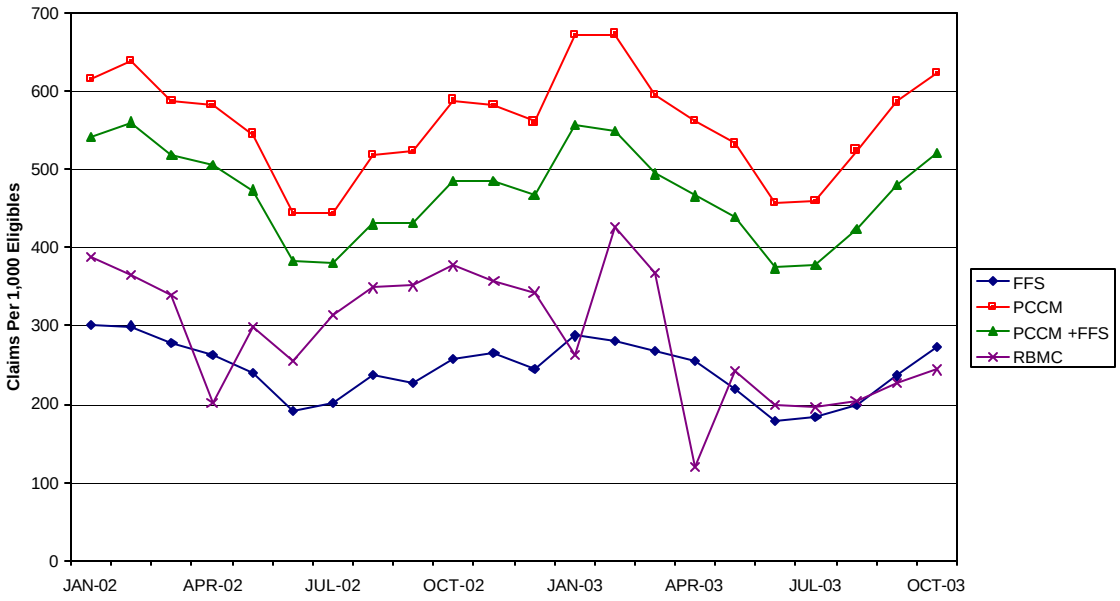


Source: Dataprobe files available through December 2003. Shadow claims (RBMC delivery system) included.

How does the utilization of pharmacy services for CHIP members compare across the three delivery systems?

As seen in the analysis of physician services, the utilization of pharmacy services for CHIP members appears to be significantly higher in the PCCM delivery system (450-650 claims per 1,000 each month) than in the RBMC delivery system (200-400 claims per 1,000) or the FFS delivery system (200-300 claims per 1,000). It is not possible to determine how significant the difference is without understanding the potential large impact of under-reporting of shadow claims by the MCOs. See Exhibit III.32 below for more details.

Exhibit III.32
Pharmacy Claims Per 1,000 Eligibles
For All CHIP Members By Delivery System
January 2002 - October 2003



Source: Dataprobe files available through December 2003.

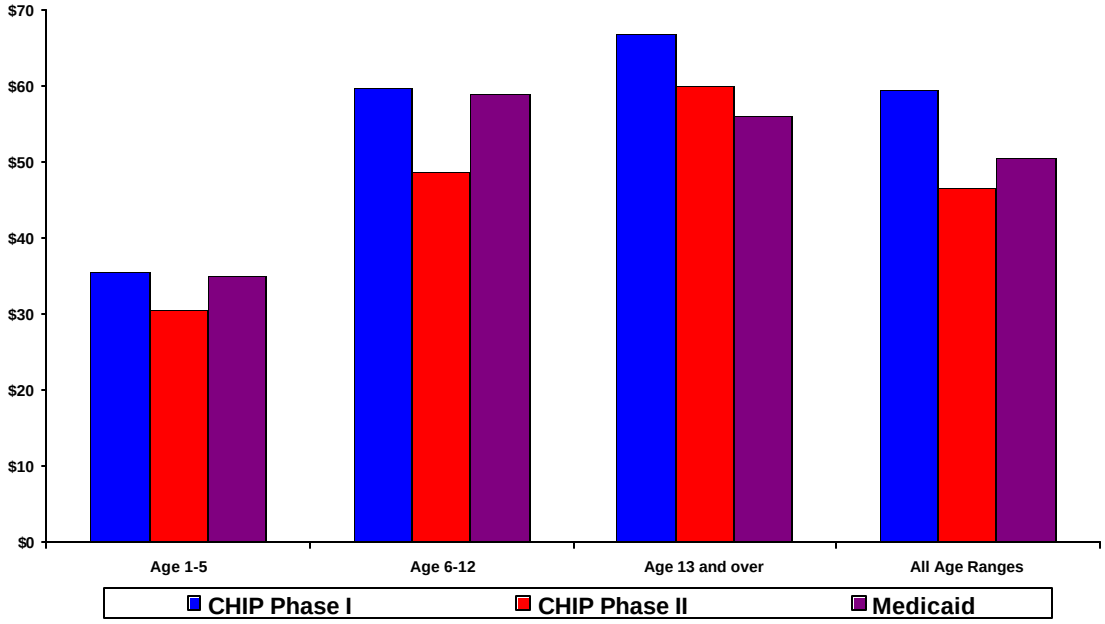
Are there variations between the costs of pharmacy scripts for CHIP and Medicaid members by age group?

As reported in prior annual reports, there are differences in the average paid per claim across age groups and these differences hold true in both CHIP and Medicaid. For example, children in the group under age five years have the least expensive claims while teenagers have the most expensive claims (see Exhibit III.33 on the next page). However, our study in the last two years showed that there is less of a difference between the average payments for children age 6-12 and teenagers, especially in CHIP Phase I and Medicaid. Further research will be needed to

determine if the children in the age 6-12 group are using the higher cost scripts found to be used by teenagers (antidepressants and tranquilizers) more prevalently now or if the reason for the increase in the average payment per claim in this age group is due to other types of scripts.

The average payment per claim remained the same from 2002 to 2003 across the board for all age groups in CHIP Phase II and Medicaid. In CHIP Phase I, the average payment per pharmacy claim increased about 10% for children in the 6-12 and 13-18 age groups.

Exhibit III.33
Pharmacy Average Paid Per Claim
For Dates of Service in Calendar Year 2003



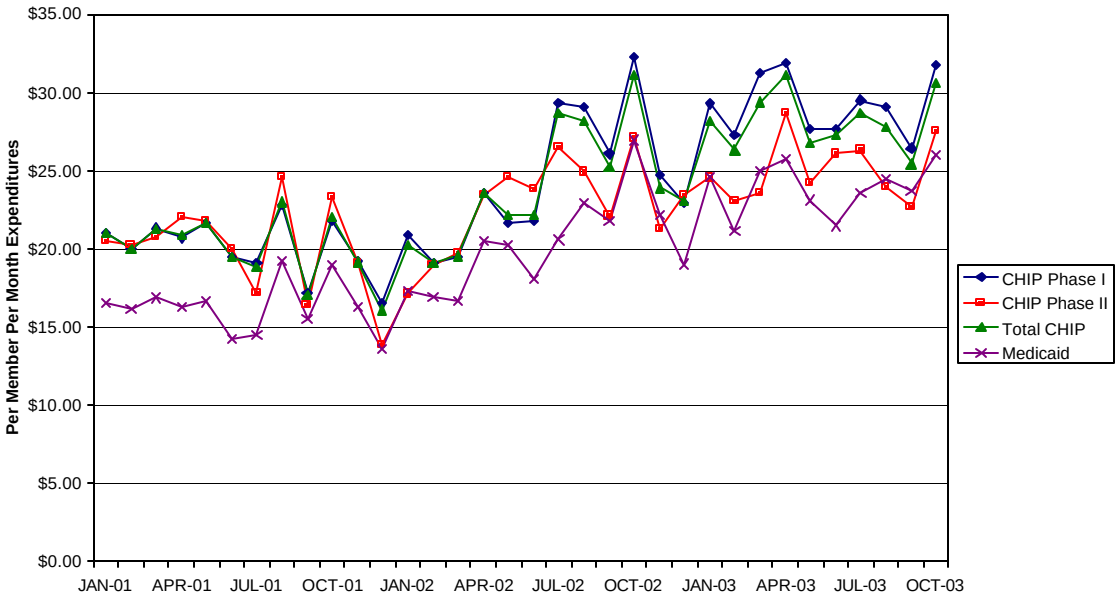
Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

DENTAL SERVICES

How do PMPM expenditures compare among CHIP Phase I, CHIP Phase II and Medicaid for dental services? Do expenditures relate to utilization trends?

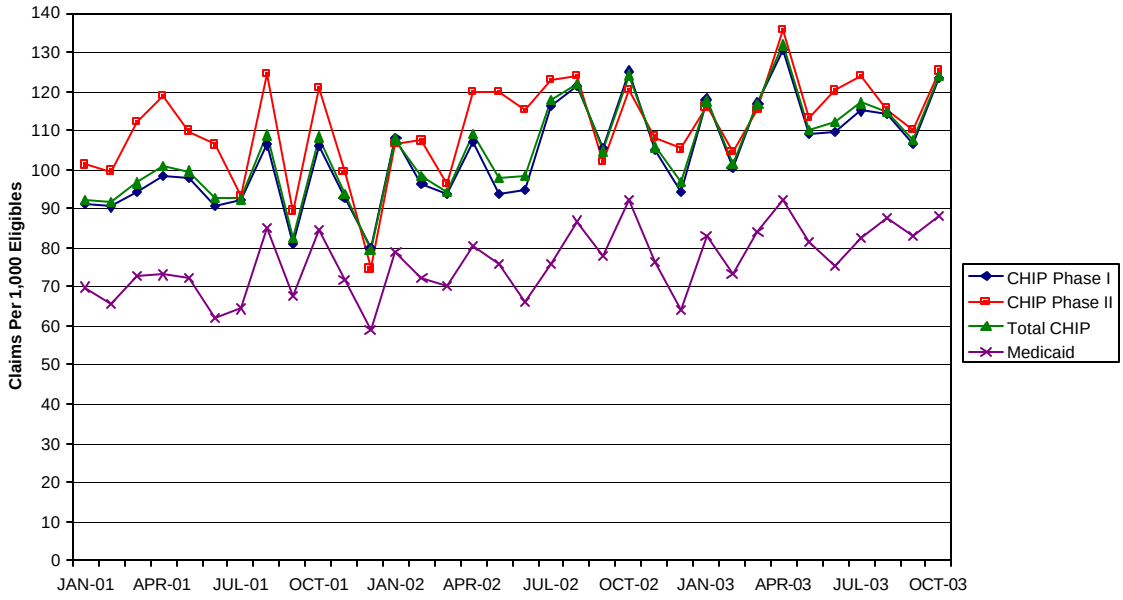
The PMPM for dental services for all children has increased close to 50% in the last three years from $20 per month to almost $30 per month (see Exhibit III.34). This appears to be a reflection of both higher utilization levels as well as higher payments per claim. Historically, children in CHIP have had higher dental expenditure PMPMs than children in Medicaid. This is mostly attributable to higher utilization of services (see Exhibit III.35 on the next page). Utilization rates for CHIP are 25% higher than for rates for Medicaid. Some, but not all, of this can be explained by the fact that Medicaid has the population of children under age one that CHIP does not have. This age group does not require dental services. Further, as has been shown since the beginning of CHIP Phase II, utilization of dental services among children in this program is higher than that for children in CHIP Phase I, but this gap is closing.

Exhibit III.34
Dental Per Member Per Month Expenditures
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

Exhibit III.35
Dental Claims Per 1,000 Eligibles
For CHIP Phase I, CHIP Phase II and Medicaid
January 2001 - October 2003

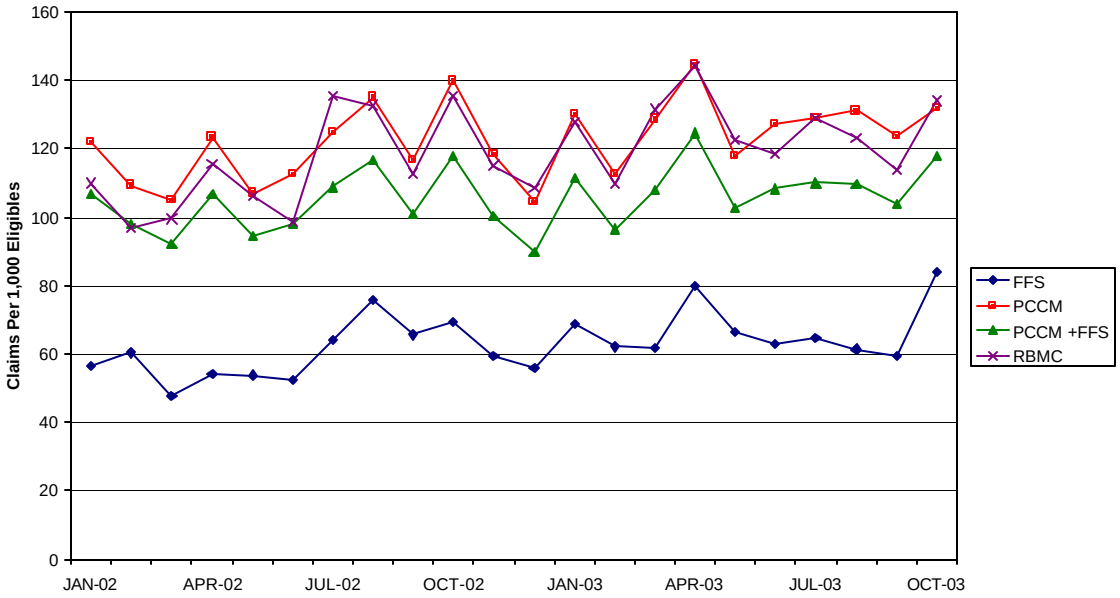


Source: Dataprobe files available through December 2003. Shadow claims (RBMC delivery system) included.

How does the utilization of dental services for CHIP members compare across the three delivery systems?

CHIP members in the PCCM and RBMC delivery systems have shown very similar patterns in dental utilization. Utilization for these two delivery systems is twice that as seen in the FFS system (see Exhibit III.36 on the next page). For purposes of analyzing utilization here, the members labeled RBMC are those members usually categorized in the RBMC system for their other services. This is noted because dental services are not covered by the managed care organizations in the RBMC delivery system.

Exhibit III.36
Dental Claims Per 1,000 Eligibles
For All CHIP Members By Delivery System
January 2002 - October 2003

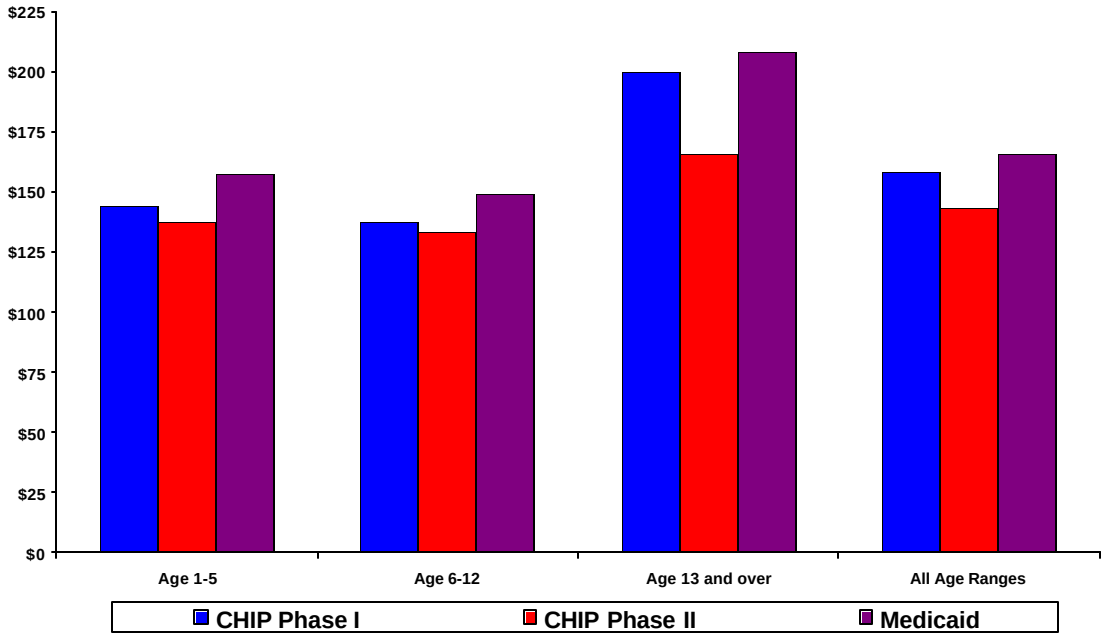


Source: Dataprobe files available through December 2003.

Are there variations between the costs of dental services for CHIP and Medicaid members by age group?

Average payments per claim for dental services were significantly higher among children ages 13-18 for all programs, a finding consistent with trends found in the last three years. For the younger age groups, average payments are the same for both CHIP Phase I and CHIP Phase II and slightly lower than for the same age groups in Medicaid (see Exhibit III.37 on the next page). The average payment per claim (across all age groups) remained steady from 2002 to 2003 in both CHIP Phase I and Medicaid and actually went down 6% in CHIP Phase II.

Exhibit III.37
Dental Average Paid Per Claim
For Dates of Service in Calendar Year 2003



Source: Dataprobe files with payments made through December 2003. Shadow claims (RBMC delivery system) excluded.

SECTION IV
EVALUATION OF ACCESS AND QUALITY DATA FROM HOOSIER HEALTHWISE MONITORING ACTIVITIES

INTRODUCTION

Section IV provides an overall perspective of how Indiana monitors the quality of and access to health care services within its CHIP program. Using both formal and informal methods, Indiana's monitoring tools enable the state to track and evaluate the operation and ongoing development of the program. A number of these monitoring tools were reviewed and our findings are presented in this section. Monitoring activities focus on the entire program. As such, many of the monitoring tools discussed below are not CHIP-specific. However, where there is information specifically related to CHIP, we have incorporated it below.

This section provides an evaluation of both formal and informal monitoring activities. Formal monitoring activities are those activities that have been instituted specifically by the state to assess the quality of health care services delivered within Hoosier Healthwise. Informal monitoring activities, on the other hand, are those that are not intended to measure quality directly, but provide some additional insight into quality-related issues.

Overall, our evaluation of the monitoring activities within the Hoosier Healthwise program yielded several key findings:

- Overall, the Hoosier Healthwise program continues to receive high ratings in its member satisfaction survey. Satisfaction among members of Indiana's CHIP program is very positive. Approximately 94% of CHIP members of the Hoosier Healthwise program rated the program as "very good" or "good", as compared to 91% of the total Hoosier Healthwise program members.

- In order to ensure that Hoosier Healthwise members access all of the services available to them, they must be adequately informed about the program. It was evident in the member satisfaction survey that some members are not receiving important information, specifically about transportation benefits. The development of an aggressive provider education strategy would assist providers with educating and informing their patients about all of the benefits available to them.

- There continues to be a concern with access to physician services. The number of full physician panels in counties continues to grow, from seven counties in December 2002 to eleven in December 2003. However, it was promising to note that member disenrollment from a PMP due to access reasons remained low. Also, the rate of children auto-assigned to a PMP continues to remain low.

- From the data available, childhood immunization rates are below the targeted goal. The implementation of the Immunization Registry (CHIRP) has allowed MCEs, individual providers and local health departments to report into one data system and effectively track vaccination coverage for children and adolescents. However, the completeness of utilization information in CHIRP is still being studied. Therefore, it is unclear as to whether childhood immunization rates shown below the targeted goal are truly a utilization issue or a data reporting (or lack thereof) issue.

FORMAL QUALITY MONITORING ACTIVITIES

Hoosier Healthwise continues to use periodic formal mechanisms for monitoring access to and quality of health care services. These include:

- Monthly Quality Improvement Committee (QIC) meetings
- Annual Member Survey
- Annual Provider Survey
- Evaluation of HEDIS Benchmarks

The results of these monitoring activities for 2003 are summarized below. Each of the several monitoring tools provides an opportunity to highlight any program quality issues that may arise. Once the issues are identified by a stakeholder within the program (i.e. members, providers, managed care entities (MCEs) and the State), each issue may be monitored over time and the appropriate corrective action can be taken.

Quality Improvement Committee Monthly Meeting Minutes for 2003

Monthly Quality Improvement Committee (QIC) meetings had at least one, usually more, representative from each of the following parties in attendance:

- Each of the managed care organizations (MCOs)
- AmeriChoice, the administrator of Prime*Step*, the PCCM program
- Tucker Alan (the federally-required external quality review organization, or EQRO, for Hoosier Healthwise)
- Office of Medicaid Policy and Planning (OMPP)

Depending on the agenda topics, some meetings also included representatives from the CHIP program, various Hoosier Healthwise contractors and additional guest speakers. A review of the minutes from the 2003 QIC meetings demonstrate that the committee continues to address some of the issues from 2002 and is actively identifying and highlighting areas that may need improvement.

MCO Reporting Manual

In March 2003, the OMPP distributed the MCO Reporting Manual to each MCO. The new manual is comprehensive and includes instructions for most reporting requirements. In order to assist MCOs with complying with the reporting requirements, each MCE received a detailed schedule of due dates for each of the required reports. OMPP requested comments and suggestions from each MCO.

In response to OMPP's request, the MCOs submitted several questions, comments and suggestions to OMPP regarding the manual. Some of the items included:

- Including a comprehensive glossary in the manual
- Changing due dates of certain reports to coincide with the Department of Insurance (DOI) report submission due dates
- Waiving the requirement to identify members with special needs until MCEs have the capacity to capture that information
- Encrypting member inquiry information in order to respond to HIPAA

Provider Education Strategy

In order to improve access to primary care services and increase HEDIS rates in certain service areas, Harmony Health Plan developed and presented to the QIC provider education strategies. The education strategies addressed two HEDIS measures that scored low rates and required a corrective action plan—access to primary care services and well-child visits. It was concluded that additional attention to data reporting by providers would help increase improve HEDIS rates.

Harmony attempted to develop strategies that would be effective but cost-efficient. Some of the activities proposed were:

- Providing information about the Vaccines For Children (VFC) program
- Determining the availability of and educating providers about member transportation
- Discussing the MCO and PMP's role in handling missed appointments
- Disseminating published HEDIS rates
- Explaining to providers that the EPSDT program is Health Watch, and directing providers to the EPSDT manual and website
- Monitoring coding practices to determine what services are provided but miscoded

In a continuous effort to improve the EPSDT screening and service rates, Harmony also gave providers an EPSDT documentation tool to record EPSDT services rendered to members. Although the tool is not required, it will be implemented as part of the quarterly reporting process. In addition, letters were sent to providers informing them of required immunizations and visits for their members who turn 18 months old.

As a follow-up to their strategic plan, there will be a review of provider medical records to determine if the enhanced provider education has impacted HEDIS rates and patient care. Results from those reviews will be presented in 2004.

Grievance Process and Reporting

The Centers for Medicare and Medicaid Services (CMS) published a final rule implementing the Balanced Budget Act of 1997 (BBA) provisions regarding Medicaid managed care. These rules were effective August 13, 2002 and states were required to come into compliance with the rules by August 13, 2003. In anticipation of the compliance date, the QIC reviewed and made changes to both the member and provider grievance process in accordance with the final rules.

First, a packet containing the members' inquiry, grievance and appeal, and the provider claims dispute template was distributed to the QIC for review. The packet also contained proposed revisions to the templates as well as a crosswalk of the suggested changes. All of the proposed revisions reflected the new Medicaid managed care rules and clarifications for MCO reporting.

The QIC encouraged MCOs to use the provider claims dispute resolution reporting forms to report claims disputes for those providers with whom the MCO does not have a written agreement (i.e. out-of-network providers). The provider claims dispute template was revised to include an advisory footnote for MCOs regarding the importance of reporting provider claims disputes.

The committee expressed concerns that member inquiries were being underreported. Because of the underreporting, the committee discussed the correct definition of a member inquiry and believed that the number of member inquiries reported should be approximately the same as the number of calls answered by the member helpline. It was agreed that a member inquiry is a question or issue raised by the member that is resolved by close of next business day. As noted in the 2003 annual report, member inquiries are reported as grievances in the quarterly reports.

Shadow Claims Workplans

As noted in the 2003 CHIP annual report, shadow claims reporting is an ongoing issue for the Hoosier Healthwise program. This was important enough that the QIC decided to make shadow claims a standing agenda item for 2003. The QIC reviewed the Shadow Claims Validation Project in July 2003. Upon review, the committee found that the timeliness of shadow claims submission was good; however, the completeness and accuracy of shadow claims could be improved.

OMPP sent a shadow claims workplan to each of the MCOs for their review. Although there were four tasks listed in the workplan, the QIC focused on two of those tasks – (1) improving the accuracy of provider contact information and (2) tracking and monitoring the timeliness, completeness and accuracy of shadow claims submission. MCOs are to use existing operational

procedures to track and monitor submission. Each MCO had to submit a draft workplan to OMPP and update the workplan monthly. Their updates were presented to the QIC at each meeting.

MCO's workplans were to focus on performance measurements and outcomes. Each of the MCOs approached the issue differently. One MCO conducted an internal shadow claims validation study that focused primarily on completeness. Another MCO makes quarterly visits to providers with 300 or more enrollees to discuss shadow claims completeness and accuracy. Finally, another MCO formed a task force which met with providers for a three-month period. In addition, the MCO faxed reminders to providers and, based on these actions, it has seen a significant increase in shadow claim submission timeliness and completeness.

During the monthly updates, the MCOs witnessed an increase in the accuracy of its claim submissions. Each of the MCOs continued implementing their initial workplans. In addition, some of the MCOs began to focus on specific claims such as pharmacy claims where acceptance rates have increased dramatically. Moreover, timeliness rates have improved as well.

Beginning in January 2004, OMPP anticipates relying on the shadow claims data to make decisions regarding a disease management program.

QIC Data Grid

The QIC Data Grid is a tool that the committee uses to track various program areas for each of the MCEs. Each MCE reports data for the program areas and the QIC reviews that data to gain insight into issues surrounding the Hoosier Healthwise program. Particularly, the QIC monitors trends within the program areas with the anticipation that the data would provide OMPP and other Hoosier Healthwise partners an advanced opportunity to resolve or at least address the outstanding issue. Some of the areas covered by the grid are:

- Member inquiries
- Grievances and Appeals (Members and Providers)
- Helpline calls/Abandonment rates
- Enrollment

One of the key concerns discussed during the QIC meetings with regard to the data grid was Helpline abandonment rates. When the abandonment rates for a specific MCE is abnormally high, this indicates that the member's call is not being answered or members are being put on hold for an extended period of time. In turn, members' inquiries or grievances are not being addressed. The MCEs with high abandonment rates usually attributed the high rates to recent informational mailings. Some MCEs hire temporary employees to assist with answering the increased amount of calls.

Member Satisfaction Survey

OMPP conducted a member satisfaction survey of Hoosier Healthwise members in all counties as of September 2002, and who were enrolled in the program greater than six months, regardless if medical services were obtained. Surveys are based on one-on-one, telephone, or in-person interviews administered by Hoosier Healthwise Benefit Advocates. Data was tracked by all Hoosier Healthwise members, CHIP Phase I and CHIP Phase II members.

Member satisfaction survey findings specific to CHIP Phase I and CHIP Phase II children are shown below and are compared to the findings of the total Hoosier Healthwise membership and to national averages based on the Consumer Assessment of Health Plan Survey (CAHPS) – Medicaid child survey tool. (Reference to "CHIP members" implies the parents/guardians of the children in CHIP). Although some of the ratings decreased in 2003, CHIP member satisfaction findings were very encouraging.

- Close to all responding CHIP members (96% Phase I, 98% Phase II) were satisfied with appointment access.

- Ninety-two percent of responding CHIP members (93% Phase I, 88% Phase II) rated physician courtesy as "very good."

- Only 17% of responding CHIP members used the emergency room for care that was not life-threatening, in the past six-month period as compared to 24% responding in the Hoosier Healthwise program. This may be due to a large percentage of CHIP members having a primary care physician before joining Hoosier Healthwise (i.e. more than three-fourths versus slightly more than half of Hoosier Healthwise members).

- Ninety-three percent of all responding CHIP members had a Hoosier Healthwise dentist visit during the previous 12-month period as compared to 80% responding in the Hoosier Healthwise program overall. This finding implies that respondents are weighted more towards those that use services. In Section III, Exhibits III.9 and III.10, however, reported that only 38% of CHIP members had a dental visit in 2002 and only 28% in 2003.

Similar to last year's findings, satisfaction among members of Indiana's CHIP program exceeded national averages of comparable surveys of children in Medicaid in all categories. The following criteria were analyzed to compare the satisfaction level of Hoosier Healthwise CHIP members to national averages.

- *Rating of Member's Overall Health.* The percentage of Hoosier Healthwise CHIP members rating their current health status as "very good" or "good" exceeded the national percentage of members in other managed care organizations. Ninety-two

percent of CHIP members rated themselves as having a "good" or "very good" level of health, as compared to 89% nationally. (See Exhibit IV.1 on next page)

- *Rating of Hoosier Healthwise Program.* CHIP members in Hoosier Healthwise slightly exceeded the national average for overall rating of a health insurance plan (specific to Medicaid children). Sixty-two percent of all CHIP members (61% Phase I, 65% Phase II) rated the Hoosier Healthwise program "very good" versus 60% of health plan members nationally. Moreover, 94% of CHIP members (93% Phase I, 94% Phase II) rated Hoosier Healthwise as either "very good" or "good" versus 87% of Medicaid health plan members nationally. (See Exhibit IV.1)

Exhibit IV.1
Members' Ratings of Their Overall Status and Their Health Plan
Percentage of Members Giving the Specified Responses

Rating Question	NCBD Scale	NCBD Average	Hoosier Healthwise Program Average			
			Total	CHIP Total	CHIP Phase I Children	CHIP Phase II Children
Rating of All Health Care	9 to 10 ("Very Good")	64%	61%	63%	65%	59%
	7 to 8 ("Good")	25%	29%	29%	26%	36%
	Combined	89%	90%	92%	91%	95%
Rating of Health Insurance Plan	9 to 10 ("Very Good")	60%	59%	62%	61%	65%
	7 to 8 ("Good")	27%	32%	32%	32%	29%
	Combined	87%	91%	94%	93%	94%

Source for National Data: National CAHPS Benchmarking Database (NCBD), Medicaid – Child Survey 2002
Source for Indiana Data: Hoosier Healthwise Member Survey Results, September 2003

- *Rating of Hoosier Healthwise Doctor*. Primary care physicians were rated "very good" 92% of the time for CHIP enrollees (93% Phase I, 88% Phase II) compared to 66% nationally (see Exhibit IV.2 on the next page).

- *Rating of Hoosier Healthwise Specialist*. Similarly, CHIP exceeded the national benchmark for member ratings of specialists they have seen. Seventy-seven percent of CHIP members rated their specialists as "very good" while only 62% of national enrollees believed their specialist warranted a "very good" rating (see Exhibit IV.2).

Exhibit IV.2
Members' Ratings of Their Personal Doctor and Specialist
Percentage of Members Giving the Top Positive Response

Rating Question	NCBD Scale	NCBD Average	Hoosier Healthwise Program Average			
			Total	CHIP Total	CHIP Phase I Children	CHIP Phase II Children
Rating of Personal Doctor	9 to 10 ("Very Good")	66%	85%	92%	93%	88%
Rating of Specialist	9 to 10 ("Very Good")	62%	76%	77%	79%	67%

Source for National Data: National CAHPS Benchmarking Database (NCBD), Medicaid – Child Survey 2002
Source for Indiana Data: Hoosier Healthwise Member Survey Results, September 2003

The member survey provided good insight into some of the areas of concern among Hoosier Healthwise members. Some of these concerns were specifically discussed in the QIC meetings and include:

- Nineteen percent of Hoosier Healthwise members reported not receiving information about transportation services.
- Approximately one-third (36%) of those who changed doctors when joining Hoosier Healthwise did so because their previous doctor was not on the list of Hoosier Healthwise providers.

Provider Satisfaction Survey

The 2003 primary medical physician (PMP) survey conducted by OMPP was mailed to all PMPs participating in the Hoosier Healthwise program in 2002. The response rate was 39% (840), which is slightly higher than last year's response rate of 36%.

The number of PMPs that are at least somewhat satisfied with the Hoosier Healthwise program declined slightly from 71% (2002 survey) to 67% (2003 survey). Of those who responded to the 2003 survey,

- 13% were very satisfied and 54% were somewhat satisfied with the Hoosier Healthwise program
- 33% were at least somewhat dissatisfied

These satisfaction results represent a slight decline regarding satisfaction and a slight increase regarding dissatisfaction from last year's survey. The results are consistent across practice types

(e.g. family practitioners, pediatricians, OB/GYNs, etc.), practice profile (e.g. solo practitioner vs. group practitioner), and geographic location.

The areas with the highest rates of satisfaction among PMPs include ease of enrolling in the network, the program provider updates and the ease of verifying patient eligibility. However, the areas with the lowest PMP satisfaction are reimbursement rates, the auto-assignment process and patients keeping appointments. These issues were also cited in last year's report to the legislature. However, the percent of PMPs dissatisfied with the auto-assignment process decreased from last year's rate of 63% to 60%.

In addition, there has been an increasing trend among PMPs who report having "too many" Hoosier Healthwise patients. In 2003, 25% of PMPs reported having a high patient load. This is up slightly from last year's rating. Unfortunately, if PMPs continually believe that they have too many Hoosier Healthwise patients and that reimbursement rates are low (61% of respondents), the state may witness Hoosier Healthwise patients having access problems due to lack of provider participation.

As noted above, in response to the provider survey findings, the QIC developed a provider education strategy. In addition, OMPP and the managed care entities are developing work plans for program improvements. Finally, OMPP has asked each MCE to provide a point person who will participate in a workgroup to identify any findings from the survey requiring further follow-up.

HEDIS Measurements

The OMPP collected 2002 data for a subset of Health Plan Employer Data Information Set (HEDIS) measures in order to assess the performance of MCEs in the Hoosier Healthwise program. OMPP analyzed and summarized the data results and outlined them in a briefing paper. Indiana-specific data for HEDIS measures were available only for the Medicaid population as a whole. The QIC did note that HEDIS 2002 rates were lower than the 2001 rates due to the addition of data from two of the MCEs that were unable to report rates last year.

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). These measures assist health care payors and consumers assess managed care organization performance. NCQA publishes annual HEDIS benchmarks separately for the Medicaid population with child-specific measures. For comparative purposes, national averages for the same HEDIS measures are presented along-side the Hoosier Healthwise averages in the exhibits that follow. NCQA data is given for both 2001 and 2002 to show how the national averages have changed over the past year.

Four Hoosier Healthwise managed care plans reported HEDIS rates:

- Harmony Health Plan of Indiana

- MDwise
- Managed Health Services (MHS)
- Prime*Step* (the PCCM program)

Five HEDIS measures addressing key health care issues concerning children, adolescents and pregnant mothers were analyzed. OMPP combined the HEDIS rates submitted by the MCE's and calculated a weighted average. Subsequently, this weighted average was compared to the 2002 NCQA median rates (50^{th} percentile) for Medicaid managed care. It is important to note that the Hoosier Healthwise data is a weighted average whereas the NCQA data is an unweighted rate across health plans. Thus, health plans with large and small numbers of members count equally in the NCQA data.

The key findings from NCQA 2001 and 2002 and Hoosier Healthwise 2002 data are discussed below:

Access and Availability of Care

HEDIS examines health plan members' access to primary care and preventative services. The benchmark measures the percent of children by age category who visited an MCO primary care practitioner at least once during the year. The Hoosier Healthwise average was slightly lower than the NCQA median for 2002 (see Exhibit IV.3 on the next page). Results for Hoosier Healthwise remained steady for the younger children from 2001 to 2002, but access decreased for children aged 7-11 during this time period.

Frequency of Care

The benchmark for well-child or well-care visits focuses on medical services provided to children and/or adolescents. The rate reported represents the percentage of Hoosier Healthwise children who visited the doctor and is categorized by age and number of visits. What is clearly evident from the data is that younger children visit the doctor more frequently than older children, both nationally and in Indiana. Approximately 89% of Indiana children and 96% of children nationwide had one or more visits to a doctor within the first 15 months of life. In Indiana, only 42% of children ages 3 through 6 had a visit to the doctor in 2002 (see Exhibit IV.4 on the next page). Results for Hoosier Healthwise children remained steady from 2001 to 2002.

Childhood and Adolescent Immunization Status

It has proven to be very difficult to measure immunization in Indiana. Over the years, it has been recognized that immunization data is likely to be underreported due to the non-submission of claims and/or records from the local health departments where many immunizations occur. In addition, the vaccine shortage affected immunization rates nationally. The Hoosier Healthwise immunization rates are substantially lower than the NCQA rates for all immunizations. Analysis of submitted data reveals immunization rates that are at least 35% below the benchmark median

for all childhood and adolescent vaccinations. Vaccinations measured include MMR, Hepatitis B, and other vaccinations recommended for children and teens. In 2002, the Indiana State Department of Health (ISDH) implemented a statewide immunization registry that aggregates immunization information in one database. This will provide MCEs access to the data and the ability to calculate their HEDIS rates for 2003.

Exhibit IV.3
Percentage of Children with a Visit to a Primary Care Practitioner

Children's Access to Primary Care Practitioners				
Age	**NCQA Medicaid Median**		**Hoosier Healthwise Program Average 2002**	**Hoosier Healthwise Program Average 2001**
	2002	**2001**		
12 Months – 24 Months	92%	93%	90%	91%
25 Months – 6 Years	81%	79%	76%	77%
7 Years – 11 Years	81%	81%	75%	81%

Source for NCQA Data: National Committee for Quality Assurance (NCQA) HEDIS Medicaid Means & Percentiles, 2001 & 2002
Source for Indiana Data: Hoosier Healthwise Briefing Paper: 2003 HEDIS Data Collection and Reporting Results.

Exhibit IV.4
Percentage of Children Receiving Well-Child Visits

Number of Visits	**NCQA Medicaid Median**		**Hoosier Healthwise Program Average 2002**	**Hoosier Healthwise Program Average 2001**
	2002	**2001**		
Well-Child Visits in the First 15 Months of Life				
No Visits	5%	5%	11%	10%
One Visit	4%	5%	9%	8%
Two Visits	7%	7%	11%	10%
Three Visits	10%	10%	14%	13%
Four Visits	14%	14%	18%	17%
Five Visits	18%	18%	21%	22%
Six Visits	36%	35%	17%	20%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
One or More Visits	57%	53%	42%	46%

Source for NCQA Data: National Committee for Quality Assurance (NCQA) HEDIS Medicaid Means & Percentiles, 2001 & 2002
Source for Indiana Data: Hoosier Healthwise Briefing Paper: 2003 HEDIS Data Collection and Reporting Results.

INDIRECT QUALITY MONITORING ACTIVITIES

In addition to the formal operational mechanisms that monitor quality, there are additional data resources that provide some more insight into quality-related issues. This portion of Section IV addresses four of these indirect informal measures of quality:

- Auto-assignment rates (the rate at which Hoosier Healthwise members are assigned to a PMP due to their failure to select a PMP within 30 days of being determined eligible for Hoosier Healthwise) may be used as an indicator of members' future access to services and satisfaction with the system.

- Disenrollment rates (the rate at which members leave Hoosier Healthwise), when associated with the reason for disenrolling, may be an indicator of program dissatisfaction.

- Physician panel capacity is an indicator of the ease of accessing physician services once enrolled in the program.

- Helpline statistics may be used to identify quality issues within the program or reveal what information enrollees are not receiving.

Hoosier Healthwise findings related to each of these measures of quality are discussed below.

Auto-Assignment

Enrollees are strongly encouraged to select a PMP when they are enrolled in the Hoosier Healthwise program. The goal is to have every member have a "medical home" and develop a patient/physician relationship with a Hoosier Healthwise PMP. If a member fails to select a provider within the 30-day period, he or she is assigned to a PMP. The auto-assignment process is a mandatory federal requirement for the Hoosier Healthwise program.

The member auto-assignment process considers several factors when linking a member and a PMP. These factors include:

- Previous PMP-patient relationship
- Existing PMP relationship within the member's family
- Geographic proximity
- Appropriate PMP scope of practice that meets member's health needs
- PMP availability to accept new members
- Available PMP enrolled in Hoosier Healthwise managed care organization

Over the years, the Hoosier Healthwise program has instituted several measures to improve the enrollment and auto-assignment process and rates. These new measures have succeeded in

reducing the default auto-assignment rate. Over the past year, children in CHIP Phase I have experienced a lower auto-assignment rate on average from 4.2% to 3.6%. CHIP Phase II continues to have the lowest auto-assignment rate at 2.1%. The combined CHIP auto-assignment rate of 3.3% is very close to that found for children in Medicaid.

Exhibit IV.5
Auto-Assignment Rates of Child Enrollees in Hoosier Healthwise

Average by Year	CHIP Phase I	CHIP Phase II	Medicaid
CY 2001	5.2%	3.0%	3.6%
CY 2002	4.2%	2.2%	3.4%
CY 2003	3.6%	2.1%	3.1%

Disenrollment

Analysis of monthly disenrollment data from 2003 is used to measure when and why members are switching primary medical providers (PMPs) within Hoosier Healthwise or disenrolling from the program altogether. As in past reports, the analyses included a focus on the most common access reasons for disenrollment from a PMP and compared them to the previous year's findings.

Within this evaluation, access is defined as both the ease with which CHIP-eligible children are able to enroll in the program as well as the access they have to services once they are enrolled. As found over the past several years, access issues represent a small percentage of the reasons Hoosier Healthwise members disenroll. Results from this year's data were found to be very promising. The following access issues are tracked:

- PMP Panel Full
- Inconvenient Location
- Network Limitations
- Transportation Problems
- Unable to Obtain Referral
- PCCM Ancillary Service Access Issues
- MCO Ancillary Service Access Issues

As seen in Exhibit IV.6 on the next page, access issues make up a very small portion of reasons for disenrolling from a PMP. Similar to last year, access issues combined make up only 3% of all reasons for disenrollments from a PMP. The main reasons that members disenroll from a PMP were (which are all not access-related) include: (1) the member is no longer eligible for Hoosier Healthwise (62%); and (2) the PMP either disenrolled from Hoosier Healthwise or changed managed care networks (13%). Panel capacity was the most frequent reason related to access for members to switch PMPs in 2003 as it was in 2002. Approximately 2.4% of all disenrollments were due to a PMP having a full panel.

Exhibit IV.6
Percent of Access-Related Reasons for Disenrollment from a PMP

Reason	Percent of Total 2003	Percent of Total 2002
PMP Panel Full	2.4%	2.1%
Inconvenient Location	0.6%	0.7%
Network Limitations	0.2%	0.2%
Transportation Problems	0.1%	0.1%
Unable to Obtain Referral	<0.1%	<0.1%
PCCM Ancillary Service Access Issues	<0.1%	<0.1%
MCO Ancillary Service Access Issues	<0.1%	<0.1%
All Access Issues	**3.2%**	**3.2%**
All Non-Access Issues	**96.8%**	**96.8%**
Total	**100.0%**	**100.0%**

Source: AmeriChoice Monthly Disenrollment Data, 2003 and 2002

Access issues also made up a small percent of reasons for disenrollment across MCEs. Prime*Step* had the highest percentage of disenrollments due to access issues (3.7%) among all of the health plans. In addition, Prime*Step* ranked the highest within the entire Hoosier Healthwise Program for the percentage of disenrollments due to access issues (1.8%). (See Exhibit IV.7) Access issues, as a percentage of total disenrollment reasons, dropped for Harmony and MDWise from 2002 to 2003, but rose slightly for MHS and Prime*Step*.

Exhibit IV.7
Access-Related Disenrollment Across Indiana's Managed Care Entities

	Harmony		MDWise		MHS		Prime*Step*	
Reason	Percent of Total 2003	Percent of Total 2002	Percent of Total 2003	Percent of Total 2002	Percent of Total 2003	Percent of Total 2002	Percent of Total 2003	Percent of Total 2002
All access issues	3.3%	4.2%	2.0%	2.5%	3.4%	3.2%	3.7%	3.2%
All Non-Access Issues	96.7%	95.8%	98.0%	97.5%	96.6%	96.8%	96.3%	96.8%
Access Issues as Percent of Hoosier Healthwise Total	0.3%		0.4%		0.8%		1.8%	
Non-Access Issues as Percent of Hoosier Healthwise Total	7.6%		20.5%		22.7%		46.0%	

Source: AmeriChoice Monthly Disenrollment Data, 2003

Pediatric PMP Panel Capacity

This evaluation examined the number of pediatric physicians enrolled in Hoosier Healthwise over calendar year 2003 in order to measure member's access to care. Pediatric providers include General Practice, Family Practice, and Pediatrician PMPs, but do not include Internal Medicine, OB/GYNs or PMPs who only treat patients older than 17.

- The number of pediatric providers has increased 5% from 1,700 in December 2002 to 1800 in December 2003.

- The average number of Hoosier Healthwise enrollees per pediatric PMP has increased 14% from 234 in December 2002 to 269 in December 2003.

- Close to half of the pediatric PMP panels are full. This is a slight decrease from 52% in December 2002 to 49% in December 2003. This capacity rate lends itself to concern regarding members' access to care through a pediatric physician.

In addition to evaluating members' access to care statewide, this study also assessed the supply of pediatric providers within the counties. Primary Medical Providers (PMPs) negotiate with the State to determine their "panel size", i.e. the maximum number of members they will accept. While understanding the actual number of pediatric physicians in each county, it is just as important to know how many of these physicians have the capacity to accept new members.

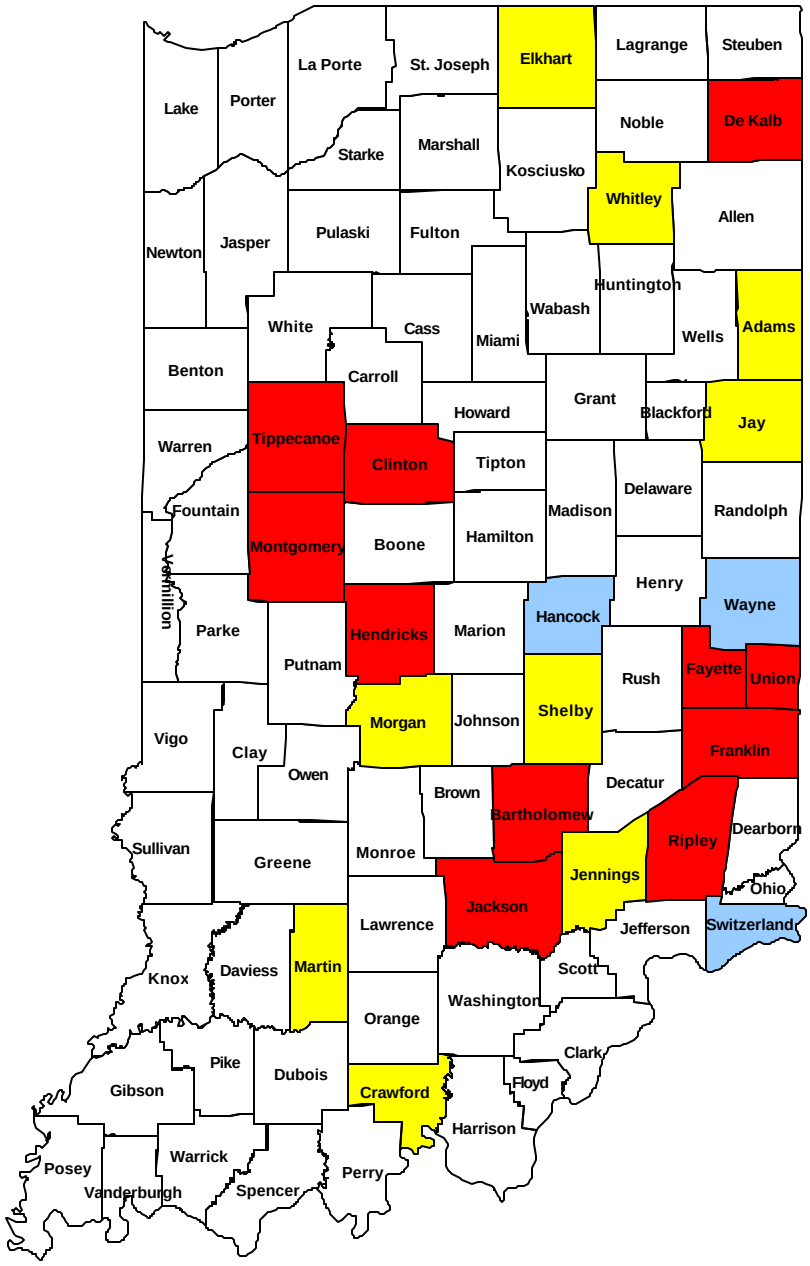
This report examined panel size on a statewide and county-by-county basis (see Exhibit IV.8 on the next page). The analysis of panel size for Hoosier Healthwise as of January 2004 showed that:

- Eleven counties had full provider panels as of January 2004. Specifically, Bartholomew, Clinton, DeKalb, Fayette, Franklin, Hendricks, Jackson, Montgomery, Ripley, Tippecanoe and Union counties have full pediatric provider panels.

- Only seven counties reported full panels last year, with Bartholomew, Clinton, Jackson, Tippecanoe, and Union being five among them. Notably, Hancock and Steuben counties are no longer at full capacity, with Hancock dropping to 99% in 2003 and Steuben significantly dropping to 63%. Bartholomew, Clinton, Jackson and Tippecanoe counties increased from full capacity to 142%, 119%, 120%, and 125%, respectively.

- A total of 23 counties had panels above 80% full as of January 2004. This is five more counties than what was reported last year. Four were in the Northern region, eleven in the Central region, and eight in the Southern region.

Exhibit IV.8
Measure of Pediatric PMP Panel Capacity By County



Percent Panel Capacity

	100% full or more (11)
	90% - 99% full (3)
	80% - 89% full (9)

Source: OMPP, January 2004

Helpline Statistics

This section examines the amount and type of calls made to the Hoosier Healthwise Helpline by members. Calls are tracked and categorized by issue codes on a month-by-month basis for 2003. Similar to 2002, the majority of calls to the Helpline by members were for recipient eligibility inquiries; however, Hoosier Healthwise members do call the Helpline to report quality-related issues and concerns. Thus, there is an opportunity to review separately the frequency of those calls as a percent of total calls received.

Overall, the volume of calls varied over the year. In addition, the number of calls to the Helpline dropped by over 20,000 calls from last year's total. The largest number of calls received by the Helpline was received in the beginning part of the year (January through May) while the numbers decreased in the second half of the year (post-July). This greatly differs from last year where the majority of calls were received in the latter part of the year. The number of calls ranged from a low of 5,900 in November to a high of 10,103 in February.

In general, calls regarding quality issues represented a very small percentage of calls to the Helpline in 2003. A small decline from last year, quality-related calls to the Helpline were only 3% of the total call volume throughout the year compared to 5% of the calls in 2002. As the total call volume fluctuated over the year for each month, the quality-related calls were relatively constant.

The following is a list of all quality-related issues that members reported in 2003:

- Appointment Delay
- Inconvenient Location
- Insufficient After-Hours Coverage
- MCO Ancillary Service Access Issues
- Physician/Patient Relationship Unacceptable
- Quality of Service Issues
- Transportation Problems
- Treatment by Staff
- Unable to Obtain a Referral
- Unsatisfactory Communication
- Unsatisfactory Quality of Care
- Untimely Communication
- Waiting Time

"Inconvenient Location" and "Unsatisfactory Quality of Care" were the two most frequent quality-related reasons members called the Helpline in 2003. This followed the same pattern as last year. See Exhibit IV.9 on the next page for further details.

Exhibit IV.9
Total Volume and Percent of Quality-Related Calls for 2003
From Hoosier Healthwise Members

	Total Calls	Total Quality-Related Calls	Unsatisfactory Quality of Care	Inconvenient Location
Total Number of Calls	92,674	2,476	646	860
Percent of Total Calls	100.0%	2.7%	0.7%	0.9%
Percent of Total Quality Calls	N/A	100.0%	26.1%	34.7%

Source: AmeriChoice, Member Issues – Helpline Only, 2003

CONCLUSION

As the findings in this section have demonstrated, Hoosier Healthwise has designed formal monitoring activities which track and address issues and concerns related to quality of and access to health care services within the program. Mechanisms such as the QIC incorporate and welcome the input and expertise of many key players within the Hoosier Healthwise system. These key players provide valuable insight into operational and programmatic problems associated with Medicaid managed care. Due to this insight, the QIC is able to offer innovative solutions to both members' and providers' concerns. In addition, the QIC, in conjunction with the member satisfaction and provider satisfactions surveys, highlighted issues surrounding provider education and member information.

The informal monitoring activities provide another perspective of the Hoosier Healthwise program. Tools such as the Helpline statistics and the rate of auto-assignments validate the fact that member satisfaction is relatively high. Also, the continuous monitoring of the disenrollment rates and the physician panel capacity alerts OMPP to potential access issues that may arise.